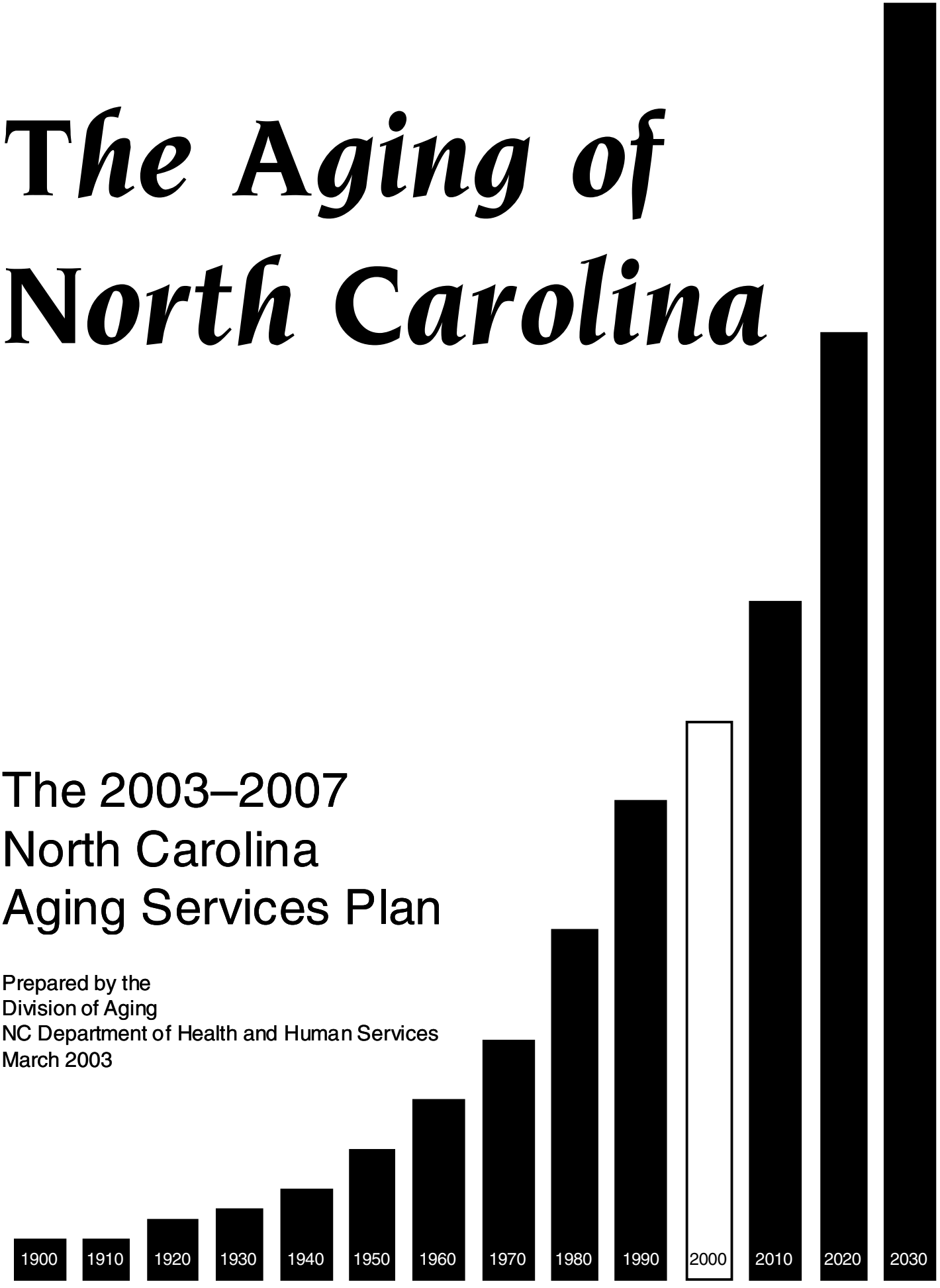
The Aging of North Carolina

The 2003–2007 North Carolina Aging Services Plan

Prepared by the
Division of Aging
NC Department of Health and Human Services
March 2003



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March 2003

The graph on the cover and title page is an abstract version of Figure 1, showing the actual and projected population age 65 and older in North Carolina between 1900 and 2030.

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Introduction

The NC Department of Health and Human Services (NCDHHS) is pleased to present the *2003–2007 State Aging Services Plan*, as required by NCGS 143B-181.1A and the federal Older Americans Act. This *Plan* serves as an update to the *1999–2003 Plan*, which provided an extensive review of trends and issues relevant to today's seniors and aging baby boomers. Available on the web site of the NC Division of Aging (NCDOA), the *1999–2003 Plan* remains a useful reference document.

North Carolina can be proud of what has been accomplished to benefit seniors and their families since 1999. Included among the achievements are the extension of Medicaid coverage to include persons age 65 and older with incomes below 100 percent of the poverty level, effective start-up of the Family Caregiver Support Program, and most recently, implementation of *NC Senior Care* to provide prescription drug assistance to seniors with low incomes and certain chronic conditions. Prescription drug assistance for seniors is a priority on Governor Easley's *One North Carolina Agenda*. We must assure that North Carolina stays on course to further improve the quality of life of our seniors and their families in the next four years.

The *2003–2007 Plan* is organized into five main chapters corresponding with what are commonly considered the essential dimensions of well-being for older adults, namely health, wealth, and social engagement. Chapter 1 provides background about the demographic impact of aging on North Carolina. The next two chapters examine the importance of healthy aging and review long-term care in North Carolina as it pertains to older adults and their family caregivers. These two chapters address for seniors and their families two priorities of my administration, that is, the seemingly intractable challenge of health disparities and the important and complicated issues of long-term care reform. Chapter 4 focuses on economic security, and Chapter 5 considers some major programs and services that help seniors remain actively engaged in their communities. Three appendices list the agendas of the major statewide advocacy groups for older adults, directions and activities of NCDHHS divisions and other agencies of state government that will affect the lives of older North Carolinians, and the state's 17 Area Agencies on Aging.

This new plan is available on the NCDOA's website (http://www.dhhs.state.nc.us/aging/home.htm) with links to additional information. The website also includes statistical and other supporting documentation that further define the issues facing today's seniors and aging baby boomers.

While the authorizing state and federal legislation require the NCDOA to develop this plan, the division has sought wide input from other state agencies and has invited participation from consumers, service providers, and educators. I wish to thank the many individuals and groups that contributed information and ideas to this plan, which will guide our work as North Carolina responds to the challenges and opportunities of an aging society. It is an especially important plan, both because of the aging of our population and because of our state's current economic difficulties. Reflecting these circumstances, the plan considers not only what government can and should do, but also the responsibilities of individuals, families, and communities.

Our collective goal is to *meet the challenges of an aging society by drawing upon the talents and resources of active seniors, enhancing services for vulnerable seniors, valuing diversity while addressing disparity, being responsible stewards of resources, and helping baby boomers prepare for their future.* I hope you will join us in supporting the plan's priorities for healthy aging, long-term care, economic security, and the development of senior-friendly communities.

Carmen Hooker Odom
Secretary
North Carolina Department of Health and Human Services

1 *Aging* North Carolina

Charting the course for North Carolina's current and future older population

North Carolina stands only a few years away from a significant demographic transition. The time to plan and prepare for an aging society is growing short. The number of seniors in North Carolina continued to grow rapidly in the decade from 1990 to 2000, as it did throughout the twentieth century. Figure 1 shows the growth in the number of people age 65 and older from the beginning of the twentieth century to 2030. Most of this growth reflects general population growth and greater longevity in North Carolina and the nation as a whole.

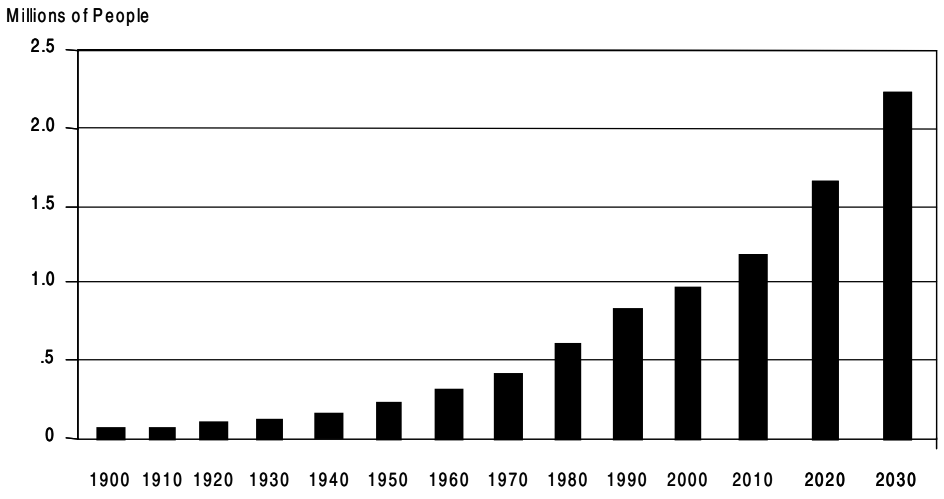
NC ranks tenth among states in the number of persons age 65 and older and eleventh in the size of the entire population (US Administration on Aging 2002). However, NC ranked thirty-sixth among states in the percentage of the population that is 65 or older. In this regard, North Carolina is still a relatively young state.

In 2000 there were 969,048 people age 65 and older living in North Carolina, making up 12 percent of the state's residents. This represents a slight, temporary decline in the percentage of older adults since the *1999–2003 Aging Services Plan*. The decrease was caused by the relatively small number of people born during the Great Depression and World War II who are now reaching their mid- to late 60s.

The growth of the older population in the twenty-first century in North Carolina, the nation, and the world is of a very different kind. As the large baby boom cohorts approach retirement age (the first boomers will be 60 in 2006), projections for the first decade of the twenty-first century show a dramatic shift. Figure 2 shows the change in North Carolina's age composition from 1970 to 2000, and the greater projected changes in 2030.

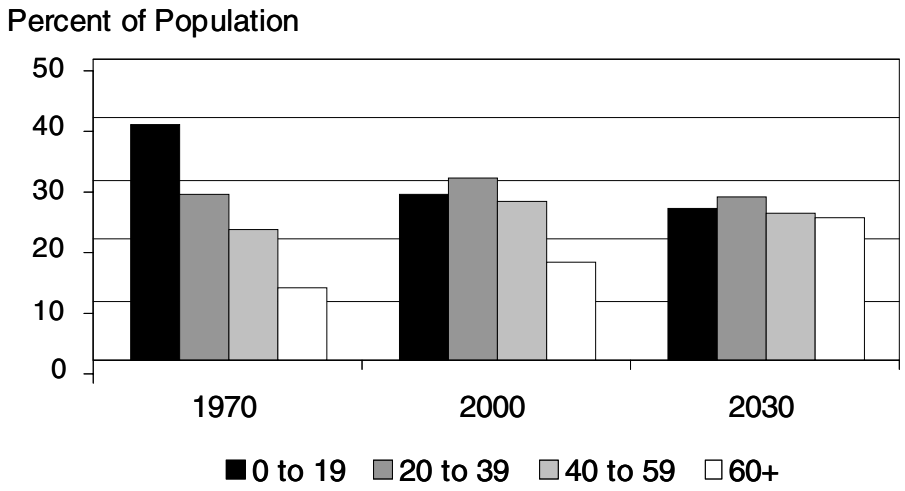
In 83 of the state's 100 counties, the rate of increase among its citizens age 65 and older (22 percent) is expected to exceed the growth of the total population (18 percent) between 2000 and 2010 (see Figure 3). In many counties, the expected discrepancy is even more dramatic. Onslow County, which has historically been kept young by its large population of military personnel and their dependents will show the greatest increase in older population, with that group

Figure 1. Actual and Projected Population Age 65 and Older, North Carolina, 1900 to 2030



Data come from the U.S. Census Bureau for 1900 to 2000 and from the NC State Data Center projections for 2010, 2020, and 2030.

Figure 2. The Aging of North Carolina's Population, 1970 to 2030



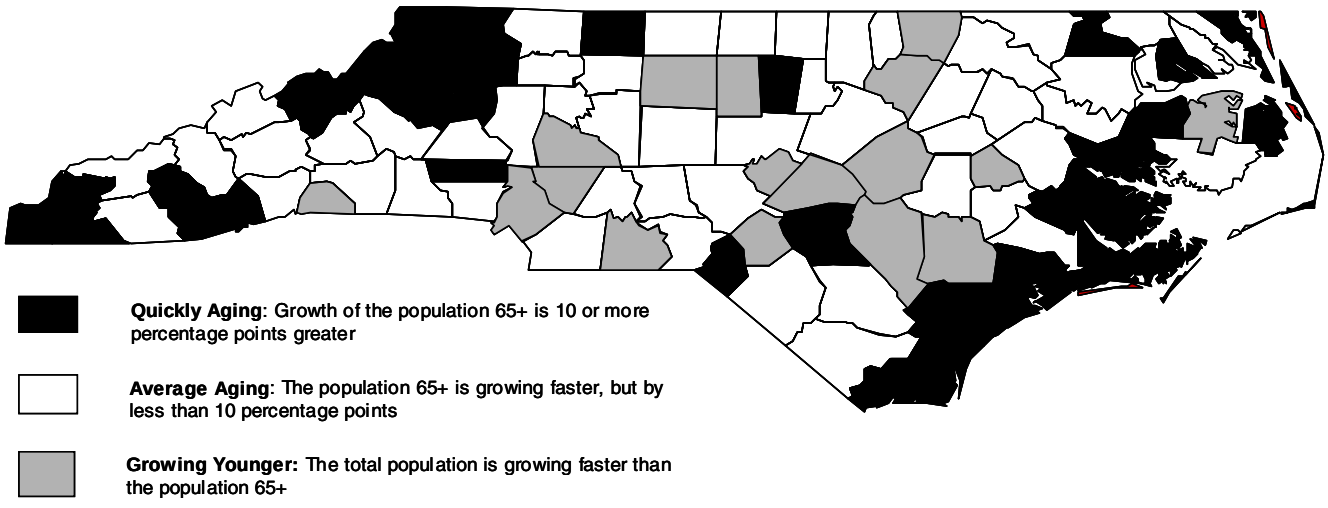
expected to grow 35 percent while the general population grows 5 percent.

As Figure 3 shows, the quickly aging counties are most concentrated, though not exclusively found, along the coast and in the mountains, where two forces may be at work to create an older population. First, these areas draw retirees because of the tendency of people to retire to areas where they have enjoyed vacationing. Second, the traditional economies of these areas do not provide enough jobs, so many of the working-age people migrate out of the county to more urban areas.

Meanwhile, some counties are actually growing younger. For example, in Hoke County the total population is growing 11 percentage points *faster* than the older population (37 percent compared to 26 percent for the 65+). Counties like Hoke that are growing younger are for the most part ones that especially attract younger workers and their families. Counties with urban areas attract more skilled and professional workers, and the coastal plains attract young Latinos with jobs in agriculture. Many of the coastal plains counties also have relatively large rural African American and/or American Indian populations that have slightly higher birth rates than their White or urban counterparts.

By 2020 the population 65 and older will have grown 71 percent from the 2000 baseline,

Figure 3. Differences between the Rates of Growth of the Older Population and the Total Population in NC Counties, 2000 to 2010



compared to 36 percent for the general population, and by 2030, it will have grown 129 percent, compared to 55 percent for the total population. Thus, by 2030, when the youngest of the baby boomers are 65, the state should have in excess of 2.2 million persons at least age 65, representing 17.8 percent of the total population.

Figures 4 and 5 show the proportion of the population age 65 and older in each county in the 2000 census and in the state projections for 2030. By using the same percentage groupings in both years, we illustrate the dramatic aging of the counties. However, seeing so many counties turn the same color (indicating *more* than 16 percent of the population is 65+) may create a mistaken impression of homogeneity. There remains a wide range of projections among those "most aged" counties from 16.2 percent (Greene) to 36.4 percent (Clay).

Figure 4. Percent of Population Age 65+ in North Carolina, April 2000

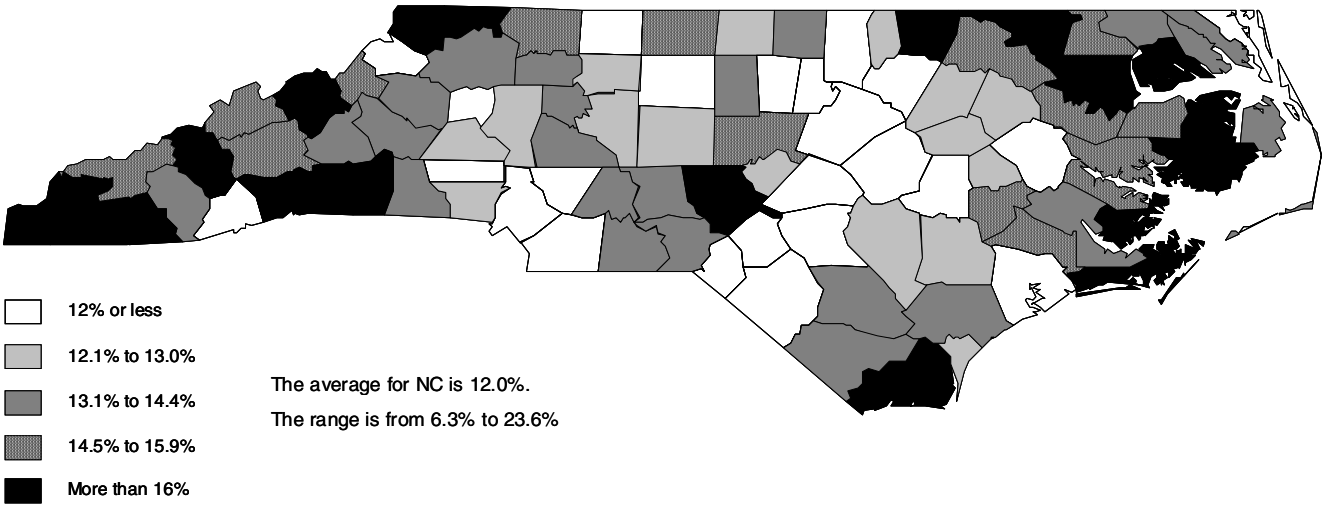


Figure 5. Percent of Population Age 65+ in North Carolina, April 2030

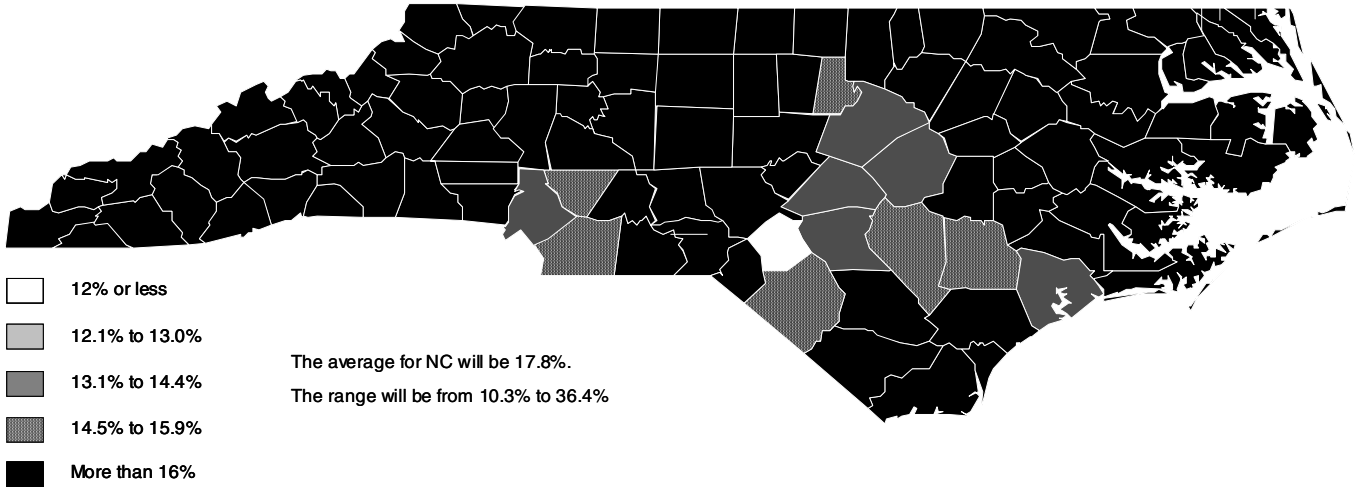


Table 1. North Carolina's Profile in Comparison to the US

	NC	US
Total Population (all ages) in 2000[a]	8,049,313	281,421,906
Percent of Population 65+ [a]	12.0	12.4
Percent of Population 85+ [a]	1.3	1.5
Percent of persons 65+ who are women [a]	59.8	58.9
Percent of persons 65+ who are African American [a]	15.9	8.3
Percent of persons 65+ who are Latino[a]	0.6	4.7
Life Expectancy at birth[b]	75.6	76.9
Life Expectancy at 60 (additional years)[b]	20.8	21.6
Percent of population 65+ in the civilian labor force [a]	14.4	13.3
Percent of population 65+ employed [a]	13.2	12.5
Percent of population 65+ with less than a high school diploma [a]	41.6	34.5
Median household income for households with heads age 65 to 74[a]	$28,521	$31,368
Median household income for households with heads age 75+ [a]	$19,307	$22,259
Percent 65+ below poverty [a]	13.2	9.9
Percent 65+ 100 to 149% of poverty [a]	12.2	10.8
Percent 65+ 150 to 199% of poverty [a]	11.0	10.7
Percent rural farm (total population) [a]	1.0	1.1
Percent rural nonfarm (total population) [a]	38.8	19.9

[a]US Census Bureau 2002, Summary File 3 (SF3).

[b]NCDPH 2002, *Healthy life expectancy in North Carolina, 1996–2000.*

How Does North Carolina Compare to the Country?

As Table 1 shows, in most respects NC is at a mild disadvantage compared to the US as a whole. While a slightly smaller percentage of North Carolina's population is older, those who are over 65 in North Carolina have a lower life expectancy, higher rate of poverty, and lower average education and income than their national counterparts.

A note about age groups

There is no magic age at which people become old. For many federal purposes, age 65 became the definition of entry into older adult status because of the original Social Security retirement age. The Older Americans Act (OAA), on the other hand, sets eligibility at age 60, and many agencies and organizations that use OAA funds keep figures for those 60 and older. Because of differing practices among sources of information, statistics throughout this document vary in reporting age groupings for older adults.

In addition to the variability in defining when a person becomes an older adult, factors such as health, employment, and marital status vary significantly among age groups within the large 60+ or 65+ categories. For this reason, this plan often incorporates information about narrower age subgroups (e.g., 60 to 64, 65 to 69). However, there is great variation in the availability of data for such subgroups. Where data are taken from several sources, it is not always possible to match information for comparable groups. This document is consistent to the degree that the content and these varying data sources permit.

Major Themes

In this first decade of the twenty-first century, the *2003–2007 NC Aging Services Plan* proposes that North Carolina accommodate and respond to the aging of its population, communities, and institutions by focusing on five major themes:

1. Drawing upon the talents and resources of active seniors
2. Enhancing services for vulnerable older adults
3. Valuing diversity while addressing disparity
4. Being responsible stewards by maximizing formal and informal resources
5. Assisting baby boomers and younger generations to prepare well for their future.

Drawing upon the talents and resources of active seniors

One of the most important legacies of the twentieth century was the extension of life expectancies. In 1900, a 20-year-old had only a 50 percent chance of surviving to age 65 and, having made it that far, had those same odds of living 11.7 years more (Institute for Research on Women and Gender [IRWG] 2002). Today, in North Carolina the average 20-year-old has a 50 percent chance of living to be almost 77 years old (76.8), while a 65-year-old has the same odds of living 17.1 more years (NCDPH 2002). However, North Carolina still has a somewhat

lower life expectancy than the US as a whole (see Table 1).

Not only are older adults living longer, but they are also living better. For example, the disability rates among older adults have been steadily declining (Cutler 2001). The health status of today's older adults has been favorably compared to that of their younger counterparts decades earlier (Manton and Gu 2001). Even the widely accepted notion of age-related cognitive decline has been challenged (Schaie 1990). Thus, it is not surprising to find that 60 percent of seniors age 80 and older continue to live independently in the community (Crimmins et al. 1999).

Today, many older adults are putting their time, talent, and experience to work. The National Council on the Aging (NCOA) has observed that retirement is not "an event" but a process, as work and retirement are no longer mutually exclusive. According to their survey, 23 percent of adults age 65 and older consider themselves both retired and working, and 19 percent are not retired at all (NCOA 2002). In North Carolina, over 14 percent of people age 65 and older are in the labor force. This total includes over 24 percent ages 65 to 69, over 15 percent ages 70 to 74, and more than 7 percent of those 75 and older (US Bureau of Census 2002, SF3, Table PCT35).

Work for pay is not the only economic contribution of older adults—they make substantial contributions to the community as volunteers, family caregivers, and community and family leaders. These contributions are discussed in greater detail in the chapters on economic security and senior-friendly communities.

The 2003–2007 NC Aging Services Plan *acknowledges the social and economic value that older adults bring to the community and supports strengthening policies and programs designed to promote wellness among seniors, enabling them to continue their active participation in family and community affairs.*

Enhancing services for vulnerable seniors

While many seniors are healthy, engaged, and living in comfortable circumstances, others face declining health, poverty, and social isolation. It is impossible to calculate the exact number struggling with issues of health, wealth, and social engagement, but some data illustrate the magnitude and intensity of the need:

- For 2005, an estimated 143,800 community-dwelling persons age 65 and older will have at least one limitation in activities of daily living (i.e., eating, bathing, dressing, moving around, or using the toilet on their own), according to the *NC Long-term Care Plan* (NC Institute of Medicine 2001). In the 2000 Census, 298,213 (30.8 percent) of people age 65 and older in the community reported some level of physical disability, while 121,874 (12.6 percent) had a mental disability (US Census Bureau 2002, SF3, Table P41).
- In SFY 2000–2001, 6,491, or 71 percent, of North Carolina's adult protective services cases involved people age 60 and older (NCDSS 2002).
- In 2000, 41.6 percent of adults age 65 or older did not have a high school diploma (US Census Bureau 2002, SF3, Table PCT25).
- As of 1999, over 337,000 persons age 65 and older lived in or near poverty (US Census Bureau 2002, SF3, Table PCT35).

The 2003–2007 NC Aging Services Plan *acknowledges that it takes the efforts of the public and private sectors, including formal and informal resources, to identify and address the needs of older adults and their families who struggle daily with health and long-term care needs, social isolation, impoverishment, and other fears and stressful realities.*

Valuing diversity while addressing disparity

Seniors vary greatly in their health, wealth, and social engagement. While no person is guaranteed a high quality of life in later years, many seniors are predictably at higher risk of hardship because of history and circumstance. North Carolina is rich in diversity, but its citizens are at risk because of the disparity that exists among all populations, including seniors. Some important differences within North Carolina's senior population relate to race/ethnicity, gender, marital status, and rurality. The prospect of a healthy and secure retirement is greatly diminished when individuals are members of certain

groups characterized by one or more of these demographic indicators, as summarized below.

Race/ethnicity. Ethnic diversity enriches our culture and gives us a variety of perspectives, new models for problem solving, and deeper insights into our own values and priorities. However, because some groups have been historically deprived of opportunity or now face the challenges of life in a new culture, ethnic diversity may translate into health and economic disparity.

The older adult population in North Carolina is ethnically diverse, but not as much so as the younger population. For example, among children in the state, over a quarter are African American, nearly 6 percent are Latino, 1.5 percent are American Indian, and nearly 7 percent are of Asian, Pacific Islander, other, or mixed ethnicity. However among those 85 and older, 16.6 percent are African American, and each of the other groups make up less than 1 percent.

The ethnic differences among age groups reflect both in-migration of young Latino and Asian families and the discrepancies in health and economic status between non-Hispanic White residents and African American and American Indian residents. Compared to the United States as a whole, North Carolina's older adults include a larger African American population and a smaller Latino one (see Table 1).

Counties differ dramatically in their ethnic composition, as in many other ways. For example, among adults age 60 and older in Cumberland County, 2.3 percent are of Latino origin, while in seven counties—Camden, Caswell, Chowan, Gates, Graham, Mitchell, and Swain—there were no Hispanic elders reported in the 2000 Census. Similarly, in Bertie, Hertford, and Northampton counties, more than half of adults age 60 and older are of African American heritage, while in Clay and Graham counties there are no African Americans reported in that age group. Reflecting historical residential patterns, there are 20 counties with no American Indian seniors, while more than 27 percent of the Robeson County population over 60 and 14 percent of the Swain County population in that age group claim American Indian ethnicity.

Nationally, statistics for African American and other older adults who are minority group members show both a higher poverty rate, 22.3 percent (US Census Bureau 2001), and a lower life expectancy, 71.8 years (CDC 2001) when compared with the White population (8.3 percent and 76.9 years). The life expectancy at birth among minority men (primarily African American) in North Carolina is 68.0 years compared to 79.6 years for White women (NCDPH 2002). Similar concerns also exist for other minority groups such as Latinos, American Indians, and some groups of Asians, where issues of race/ethnicity and health are closely entwined with the socioeconomic challenges facing these groups.

Gender. Nearly 60 percent of North Carolinians age 65 and older are women. This is about 1 percentage point higher than in the US as a whole (see Table 1). The higher rate of poverty among older women remains a primary issue today. Several major factors contribute to their diminished economic circumstances. During their working years, women continue to lag behind men in earnings and benefits (e.g., the median earnings by female workers employed full-time was $24,978 or 77 percent of men's earnings in 2000 in North Carolina according to the US Census Bureau [2001]). One explanation of the lower earnings by women is their intermittent work history due to their role as the primary family caregiver of children and parents. Furthermore, by virtue of living an average of six years longer than men, women are more likely to decrease their financial security by financing the uninsured medical and long-term care expenses incurred by ill husbands. Because of these and other factors, women age 75 and older are twice as likely to be poor as men the same age, and African American women age 75 and older are six times as likely to be poor as White men the same age (IRWG 2002).

Marital status. Being unmarried (widowed, divorced, separated, or never married) increases a woman's vulnerability to poverty (Weitz and Estes 2001). According to the Social Security Administration (1998), 50 percent of unmarried women rely on Social Security for 80 percent of their income, and 25 percent rely on Social Security as their sole source of income. At the same time, women are at much greater risk than men of being unmarried. Table 2 shows the percentage of older women and men who are unmarried—never married, widowed, or divorced. As the table shows, after ages 60 to 64,

women are more than twice as likely to be unmarried as men in their age group. Thus, their chances of remarrying are drastically reduced.

Table 2. Percent Not Married* by Gender and Age for Older Adults in NC, 2000

	Age Groups				
	60–64	**65–74**	**75–84**	**85+**	**Total 60+**
Women	33.1	45.4	65.8	76.5	51.3
Men	17.9	18.7	25.2	39.4	21.0

*Not married does not include those who are still married but separated.

Rurality. Nearly half of North Carolina's seniors live in rural areas. While these areas vary greatly in their character and resources, the *State of the South 2000* report (MDC 2002) summarizes the difficulties many of them face as their populations age. For example, during the 1990s, high-poverty rural counties lost thousands of young people and working-age adults to the South's growing cities. (Many communities count high school graduates as their biggest export.) Left behind are place-bound people lacking education and skills sought by employers—high school dropouts, single mothers, and older adults—as well as people with deep roots who simply do not want to leave. They and their communities face a long list of challenges—isolation by distance, lagging infrastructure, sparse resources that cannot adequately support education and other public services, racial and ethnic divisions, and weak economic competitiveness.

These statistics about ethnicity, gender, and rurality are important to the extent to which they raise questions and concerns that will help guide our future development of effective policies and programs that address the disparities that exist across the life course. North Carolina must address disparities among all North Carolinians.

> *In endorsing the Governor's concept of One North Carolina, the* 2003–2007 NC Aging Services Plan *acknowledges that North Carolina should take pride in and build upon its diversity, but not allow this diversity to translate into disparity that threatens the well-being of seniors and their families.*

Being responsible stewards by maximizing formal and informal resources

When the *1999–2003 Plan* was being finalized, North Carolina's fiscal picture looked much rosier than it does today. In fact, the 1998 session of the NC General Assembly (GA) increased funding for aging programs, including an expansion of Medicaid to cover older and disabled adults up to 100 percent of the poverty level. However, recovery from Hurricane Floyd in the fall of 1999 started a downward economic spiral. The 2000 legislative session marked the first time in eight years that the state's revenues came in lower than forecast, resulting in a budget shortfall of $135.3 million, which grew to $1.6 billion by 2002.

While one can hope for an improved situation, the state's budget will likely be constrained for the next few years. In this environment, it is difficult to imagine any major new state-funded initiatives that would directly benefit seniors. The introduction of *North Carolina Senior Care* as a source of prescription drug assistance for seniors was only possible because of the funds made available from the Health and Wellness Trust Fund Commission through the tobacco settlement.

This fiscal reality requires careful stewardship of available public resources and outreach to all sectors to assist in addressing the needs of vulnerable seniors and their families. In setting priorities and launching initiatives, the voices of consumers and their advocates must continue to be heard. Some of the major organizations and bodies representing the interests of North Carolina's seniors include the Senior Tar Heel Legislature, the Governor's Advisory Council on Aging, the Study Commission on Aging, and the Coalition on Aging, which includes the AARP and many trade and consumer organizations (see Appendix A for the priorities of advocates).

> *Faced with today's fiscal austerity and tomorrow's demographic imperatives, the* 2003–2007 NC Aging Services Plan *acknowledges that the important issues of an aging society require both public and private responses and individual and community actions and that all of the aging initiatives must be relevant, efficient, and well integrated into the state's agenda for the future.*

Assisting baby boomers and younger generations to prepare for future

Aging of the baby boom generation (including those born between 1946 and 1964) is adding a new dimension to the concerns of societal aging in North Carolina and the nation. After becoming eligible for services under the Older Americans Act in 2006 at age 60, the first waves of the baby boomers can start drawing Social Security benefits at a reduced rate in 2008. According to AARP (2001), 60 percent of workers today take Social Security benefits at age 62, making this the most common retirement age in the US. By 2011, at age 65, the oldest baby boomers will become eligible for full Social Security as well as Medicare. By 2030, 2.2 million North Carolinians, including many baby boomers, are expected to have reached age 65 and older. This figure represents 17.8 percent of the nearly 11 million North Carolinians projected for that year (NC State Data Center 2002).

These projections suggest the far-reaching implications of the aging baby boom generation for the state's capacity to provide health and long-term care services while protecting the economic security of older adults.

> *The* 2003–2007 NC Aging Services Plan *acknowledges that North Carolina's future success will depend largely on how well its baby boomers are prepared for their senior years and how accepting and prepared all communities are to the changes brought on by this large population group.*

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2 Healthy Aging

Promoting optimal physical, mental, and social well-being and function among older adults

Major Accomplishments (1999–2003)

- ✓ *NC Health Objectives for the Year 2010* established measurable targets for improving the health of seniors.
- ✓ NC Department of Health and Human Services (NCDHHS) selected health disparities as a major issue and priority for action.
- ✓ NC Healthy Aging Network was funded as one of seven in the nation to strengthen collaboration between public health and aging.
- ✓ The new NC Senior Care Program includes $9 million over 3 years to help educate and counsel seniors in medication management.
- ✓ NCDHHS secured federal and private grants for cardiovascular health, diabetes, cancer, nutrition, physical activity, and healthy aging.
- ✓ The NC End of Life Care Coalition was formed in 1999, and the NC General Assembly established a new online Advance Health Care Directives Registry in 2001.
- ✓ Governor Easley proclaimed September 2002 as Healthy Aging Month.

Current and Future Concerns

- ✓ Healthy aging requires a commitment from individuals, government, and society.
- ✓ Additional and flexible funding is needed to advance healthy aging collaboration effectively.
- ✓ The health of seniors and aging baby boomers varies greatly by race, class, and other factors.
- ✓ With a rapidly aging population, improving access to dental care, mental health care, and medication management will become increasingly important.
- ✓ While quality of life and costs of care are important reasons for advance planning, many individuals and families resist accessing services to assist with end-of-life care.

The scope of health policies and programs for older adults has broadened dramatically in the past decade. In their influential book *Successful Aging*, Rowe and Kahn (1998) advanced the notion that the absence of disease or disability constitutes an important, but not sufficient, basis for aging well. Their view has gained wide acceptance and support, resulting in further adaptations of their model. The framework for this chapter is drawn from all of these efforts and addresses three key factors associated with aging well: (1) preventing chronic disease and injury, (2) optimizing mental and physical function, and (3) engaging with life. Additionally, a discussion on strengthening the aging-health collaboration for optimizing health promotion is presented to clarify North Carolina's direction for promoting healthy aging.

The NC Division of Aging (NCDOA) convened an advisory group in June 2002 to discuss health issues facing older North Carolinians and to set priorities for the future. Based on the advisory group's recommendation, the definition of *healthy aging* developed by the Prevention Research Center Healthy Aging Research Network (funded by the Centers for Disease Control [CDC]; PRC 2002) was adopted with modifications, to guide North Carolina's health policies and programs affecting older adults:

> *Healthy aging is the development and maintenance of optimal physical, mental, and social well-being and function in older*

adults. Individuals, government, and communities share responsibilities in promoting and maintaining attitudes and behaviors known to advance and preserve health and well-being among older adults by providing or using health and other appropriate services effectively to prevent or minimize the impact of acute and chronic disease on function.

As the definition implies, healthy aging requires a lifelong commitment from individuals for healthy life-style practices, as well as support from government and society in general for a safe and healthy environment and an effective service system.

Demography and Healthy Aging

North Carolina is very much a part of the worldwide longevity revolution. According to the latest estimate from the NC State Center for Health Statistics (NCSCHS 2002), babies born today in North Carolina are expected to live, on average, to the age of 75.6 years. This is an impressive gain compared to the average life expectancy of 49.2 years in the United States a century earlier (Federal Interagency Forum on Health-Related Statistics 2001).

While increased longevity suggests improvements in health and health care, the quality of life of these added years remains a major concern today. The CDC (1999a) estimated that about 80 percent of all adults age 65 and older have at least one chronic condition, and 50 percent have two or more. In North Carolina, this would mean an estimated 775,000 older adults have one chronic condition, and 482,000 have at least two. Nevertheless, according to a recent report based on an annual telephone survey,
71 percent of older North Carolinians between 65 and 69 say that their health status is good, as do 55 percent of those who are 80 or older (NCSCHS 2002). The gap between estimates of morbidity and older adults' self-perceptions illustrates how older adults adapt to living with chronic conditions. However, it may also reflect a common misconception that pains and aches are part of aging and therefore unavoidable.

Today, the conventional approach of viewing older adults as a single population age 65 and older (largely based on the eligibility criterion for Social Security and Medicare) is changing. The variability in risk of health problems for different age groups is illustrated in the age-related increase of people with Alzheimer's disease. At age 65, only about 1 percent of the population has this disease. However, the prevalence doubles every 5 years thereafter to 47 percent among adults age 85 and older (CDC 1999a). For this reason, a new publication on older adults' health in North Carolina, *Health Profile of Older North Carolinians*, presents health data in four separate age categories: 50 to 64, 65 to 74, 75 to 84, and 85+ (NCDPH and NCDOA).

An increasing number of health programs today also pay closer attention to subgroups within the population, because some subgroups are at substantially higher risk for certain chronic conditions. For example, higher death rates from heart disease and stroke have been reported among African Americans and other racial minorities (NCDPH 2002a). Similarly, the prevalence of diabetes among Native Americans has been reported to be four times as high as the national average (NCDPH 2001a). The Eastern Band of Cherokee Indians participates in the CDC-funded Racial and Ethnic Approaches to Community Health (REACH) project to reduce diabetes among its members. Because of their relatively recent arrival in North Carolina, there is very limited health data on the older Latino population.

Women's health has also received more attention. For example, the *Wisewoman* project (NCDPH 2002b) is designed to reduce cardiovascular disease in women by providing preventive measures to women ages 40 to 64 with low incomes through health screening, life-style intervention, and referral services.

Vietnam-era veterans also warrant special attention because they are the older adults of the near future. The Veterans Administration (VA 2001) cites the aging of 8.4 million Vietnam-era veterans (between 45 and 59 years old in 2002) nationwide as a major challenge to the system in coming years. Of the 772,000 veterans living in North Carolina, almost 260,000, or 34 percent, are Vietnam-era veterans, and another 320,000, or 42 percent, are age 60 and older. Combined, the VA faces the need to expand its aging services to over 580,000 veterans in North Carolina.

Preventing Chronic Disease and Injury

While chronic diseases are among the most prevalent and costly, they are also among the most preventable of all health problems (CDC 1999a). In recent decades especially, scientists have become increasingly capable of distinguishing the natural aging process from the manifestation of illnesses that are common in old age (Rowe and Kahn 1998). Accordingly, an increasing emphasis has been placed on extending healthy years later in life through disease prevention, health promotion, educational activities, and other arenas of support.

In 2001, the NC Governor's Task Force for Healthy Carolinians developed *NC Health Objectives for the Year 2010* to address the health needs of the state's 8 million citizens. The list includes many objectives relevant to healthy aging and is consistent with the federal policy of setting national health goals for each decade. The report identified chronic disease as a major concern, and the task force set specific goals to reduce their prevalence, increase prevention activities, and promote healthy life-styles. The major chronic diseases they identified include the following.

Cardiovascular disease includes heart disease, the leading cause of death among older adults both nationwide and in North Carolina, and stroke, third on the list (NCSCHS 2001). Cardiovascular disease accounted for over 40 percent of deaths among older North Carolinians in 2000. In particular, the coastal plains region of North Carolina, labeled by some as the *Buckle of the Stroke Belt* (CDC 2002a), has the fourth highest stroke death rate in the nation (CDC 2001).

Cancer is the second leading cause of death among older adults in North Carolina (SCHS 2001). Incidence rates increase dramatically with age (NCDPH 2002c), which means that North Carolina will see significantly increasing cancer morbidity and mortality rates in coming years as the state population ages, even if there are significant improvements in prevention and early detection and treatment.

Diabetes is a major contributor to heart disease, stroke, blindness, renal failure, and nontraumatic amputations in older adults, in addition to being the sixth leading cause of death among older North Carolinians (NCSCHS 2001).

Injuries. Accidental falls were the most frequent causes of unintentional injuries, the eighth leading cause of death among older adults in North Carolina in 2000 (NCDPH 2001b). Falls account for 87 percent of all bone fractures for adults 65 years and older; 60 percent of fatal falls among older people happen at home (CDC 2000).

Arthritis is the leading cause of disability in the nation. In 2000, 64 percent of North Carolinians age 65 and older reported having arthritis (CDC 2002a).

Osteoporosis and related conditions affect over 1.2 million North Carolinians, causing over 34,000 bone fractures in 2000. Osteoporosis is a very manageable disease, yet the vast majority of people with osteoporosis are undiagnosed and untreated (Proctor & Gamble Pharmaceuticals 2002).

Overweight and obesity. The proportion of Americans with obese and overweight conditions has doubled since 1980 (CDC 2002), increasing the risks for heart disease, high blood pressure, diabetes, arthritis-related disabilities, and some forms of cancer. Today, 40 percent of North Carolinians age 60 years and older are considered overweight, and another 24 percent are obese (CDC 2002a).

Use of tobacco products is associated with heart disease, cancer, and chronic lung disease. In North Carolina, 26.1 percent of all adults reportedly smoke cigarettes. This percentage places North Carolina seventh in the nation, exceeding the national average of 23.2 percent of adults using tobacco products (CDC 2002a).

Physical inactivity can increase a person's risk of heart disease, colon cancer, diabetes, and high blood pressure. In contrast, regular exercise is known to contribute to healthy bones, muscles, and joints; help relieve the pain of arthritis; and reduce symptoms of anxiety and depression. In North Carolina, only 24.5 percent of adults age 65 and over meet the recommended level of exercise (i.e., 30 minutes of brisk walking five times a week). North Carolina ranks among the bottom ten states in this category (CDC 2002a).

Poor nutrition increases the occurrence of heart disease, stroke, some types of cancer, diabetes, and osteoporosis. While healthy

nutrition includes a diet low in saturated fats and five or more servings of fruits and vegetables each day, 77.9 percent of adults in North Carolina report eating fewer than these recommended servings (CDC 2002a).

Urinary incontinence is present in 15 to 30 percent of adults age 65 and older in the community and in about 50 percent of all residents in long-term care facilities (CDC 1991). Although urinary incontinence can be effectively prevented in many cases, it often is not, and this may cause embarrassed older adults to withdraw from social activities.

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The age-related change in the immune system makes older adults more susceptible to infections such as influenza and pneumonia (Williams 1995). In North Carolina, adults age 65 and older constitute over 88 percent of deaths from pneumonia and influenza, despite the free vaccination program available for seniors through Medicare and Medicaid. Among all Medicare beneficiaries age 65 and older, the immunization rates in 2000 for influenza and pneumonia were 43.5 percent and 35.5 percent, respectively (MRNC 2001a, b), so this remains a major public health concern.

Immunization rates among African Americans in 2000 were particularly low, at 24.2 percent for influenza and 22.9 percent for pneumonia. *NC Health Objectives 2010* identified the elimination of the health disparities such as this as a critical crosscutting theme for this decade. Supporting this position, the NCDHHS formally designated this as one of its four action priorities in 2001 and established its Steering Committee on Eliminating Health Disparities. Improving cultural competency of health care and human services professionals (i.e., the capacity to serve clients appropriately and effectively in cross-cultural settings) is a key strategy as North Carolina's population becomes more diverse.

Optimizing Mental and Physical Function

A popular saying about healthy aging is that one should strive to "die 'young' as late in life as possible," maintaining one's mental and physical faculties throughout the later years. Many factors influence the achievement of this goal, some of which are more controllable than others. For example, Alzheimer's disease can have a devastating effect on cognitive and physical functioning and remains difficult to prevent or treat, while dental caries can be prevented and treated.

According to the 2000 Census, over 420,000, or 45.7 percent, of North Carolinians age 65 and older responded that they had at least one disability (US Census Bureau 2002). While Manton and Gu's recent landmark report (2001) suggests that disability rates are declining among older adults, the coming wave of baby boomers will result in more people who have disabilities, so improved strategies for preventing them or minimizing their effect are vital. Here are several areas of particular importance.

Mental Health. According to the first Surgeon General's Report on Mental Health (USDHHS 1999), almost 20 percent of people over age 55 experience mental disorders that are not part of "normal aging." These conditions can severely limit social engagement (identified as one of the three factors for healthy aging) and general health. A 2002 report from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) notes that while the efficacy of treatment for mental health problems is well documented, older adults often do not recognize the need for or availability of treatment, resulting in gross underutilization of mental health services.

The prevalence of major mental health problems among adults age 65 and older is estimated at 11.4 percent for anxiety, 6.4 percent for cognitive impairment, and 4.4 percent for depression and other mood disorders (SAMHSA 2002). Estimated prevalence rates for "heavy alcohol use" range from 3 to 25 percent (SAMHSA 1998). Suicide rates increase with age, with older white men being at six times greater risk for suicide than the general population (Hoyert et al. 1999).

The NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NCDMH/DD/SAS 2001) identified older adults with mental health problems as a priority population in the *State Plan 2002: Blueprint for Change*. Further, in a letter written to Governor Easley in 2002, the NC Mental Health Planning and Advisory Council recommended that the

state "begin to develop new ways of reaching out to the elderly population." These actions in North Carolina are in step with the new federal initiative between SAMHSA and the National Council on the Aging (NCOA) to develop a strategy to use the Area Agencies on Aging (AAAs), county aging departments, senior centers, and aging services providers as the vital link between older adults and mental health services (SAMHSA 2002).

Hearing and Vision Loss. Impairment in hearing and sight are common among older adults and can contribute to inactivity, limitations in communication, and social isolation. Impairment rates increase significantly among adults age 70 and older. The CDC reports that about 20 percent in this group have vision problems that place them at greater risk of falls and other injuries. Similarly, they estimate that 25 percent of persons between 70 and 74 have impaired hearing, and this rate increases to 50 percent by age 85 (CDC 1999b).

North Carolina provides a wide range of supportive services to people with sensory and physical disabilities. While these programs typically serve people of all ages, services designed to meet the needs of older adults are being expanded. For example, the NC Division of Services for Blind runs *Mini Centers*, a training and outreach program for older adults with visual impairments. The NC Division of Services for Deaf and Hard of Hearing spearheaded development of *Adults Accessing Augmented Communication Technology (AAACT)*, an outreach initiative focused on older adults with hearing impairment. The NC Division of Vocational Rehabilitation offers the *North Carolina Assistive Technology Program,* which targets older adults and persons with visual and hearing impairments. As the older population grows, these and other programs must expand in a collaborative way.

Access to Dental Care. Poor dental health causes not only pain and suffering, but it also leads to malnutrition, infections, and other health problems and can contribute to low self-esteem and social withdrawal (USDHHS 2000). However, according to CDC (2002b), only 22 percent of older adults are covered by dental insurance, and most pay dental expenses out-of-pocket because they are not covered under Medicare. (Dental assistance is available under NC Medicaid.) Poor access to dental care poses a serious problem for older adults living at home and in long-term care facilities. Older adults with the poorest oral health are those who are economically disadvantaged, who lack insurance, who are members of racial and ethnic minorities, and who are women (CDC 2002b).

Compounding the problem, part or all of 54 of North Carolina's 100 counties are identified as Dental Professional Shortage Areas owing to economic or geographic barriers (NCORDRHD 2002). North Carolina recruits health care professionals including dentists to the underserved communities, many of them in rural areas, using the Loan Repayment Programs as a primary incentive. The dental recruitment program has placed close to 80 dentists since its inception in 1998.

Medication Management. Many older adults use medication to help manage cognitive and physical problems, and their use of multiple prescriptions and over-the-counter drugs places them at increased risk of misuse and adverse drug reactions. Since 2001, North Carolina has taken two major steps to make medication management assistance accessible to seniors statewide. First, in 2001 the NCDOA instituted a new spending provision for medication management programs under Title III-D of the Older Americans Act, which required nearly a quarter of disease prevention and health promotion funding to be allocated for medication management services, screening, and educational efforts. (The total Title III-D funding for FY 2000–2001 was a little over $450,000.) In 2002 the NC Health and Wellness Trust Fund Commission allocated $3 million per year for three years in tobacco settlement funds for medication education and counseling programs to complement prescription drug assistance under the new NC Senior Care Program. The AAAs in the Regions C, G, N, O, P, and Q, are among those receiving funding from the Health and Wellness Trust Commission to implement the "prescription assistance center" program. These centers assist citizens with low incomes in obtaining prescription drugs and counsel seniors about safe use of their medications. Other community-based programs are also available in some counties to help older adults with limited incomes obtain effective and affordable medications

(Senior PHARMAssist 2002). (Prescription assistance under the Senior Care Program is discussed in the chapter on economic security.)

Older People with Developmental Disabilities. The growth of the older population with developmental disabilities is an important aspect of aging in North Carolina. The North Carolina Task Force on Aging and Developmental Disabilities (2001) noted that these adults are increasingly outliving their parents and are at risk of losing their primary support. The demographic information about this population in North Carolina is still incomplete, but the estimated number of adults age 60 and older with developmental disabilities ranges from 5,400 to 13,000. In *Aging and Developmental Disabilities: A Blueprint for Change* (2001), the task force made recommendations to coordinate community resources, family support, guardianship, housing, and transportation to help these older adults remain in the community with adequate support.

Engaging with Life

One of the most important aspects of healthy aging is to focus attention on the value of staying engaged throughout life. According to Rowe and Kahn (1998), maintaining close relationships with others and remaining involved in activities that are meaningful and purposeful are important not only for the fit and active senior, but also for persons with lifelong disabilities and those facing the end of life.

Studies have shown that intelligence and productivity do not necessarily diminish as people age, especially when they immerse themselves in rewarding lives with their families, friends, neighbors, and colleagues (Rowe and Kahn 1998). The overwhelming majority of North Carolinians engage in active, productive lives: many are strongly involved in their churches and other faith-based activities, and many become volunteers, advocates, and activists for the larger good of society. According to a statewide survey conducted in 2000, almost 60 percent of adults age 60 and over volunteer (Guseh and Winder 2001)—about 764,000 senior volunteers in North Carolina.

In addition to volunteering, an increasing number of older adults are choosing to stay employed. According to the 2000 Census, approximately 130,000 North Carolinians age 65 and older are gainfully employed today. Lifelong learning and participation in leisure activities are other beneficial ways of staying engaged. Each of these helps older adults remain mentally and physically active, creating opportunities for emotional gratification and validation of their worth as contributing members of the community.

North Carolina's challenge is to make opportunities for social engagement fully accessible to all older adults. In addition to expanding enrichment programs at senior centers, community colleges, universities, and other venues, improving the availability of auxiliary services such as convenient transportation is critical in improving access to these opportunities.

An indispensable component of engaging with life is end-of-life care, which includes palliative and hospice care, advanced care planning, and support for bereavement. Hospice care is considered to be the "gold standard" in end-of-life care, both in terms of quality of care and cost-effectiveness (Miller et al. 2002), and it is covered by both Medicare and Medicaid. Nevertheless, the overwhelming majority of older North Carolinians still do not use available hospice benefits that could be helpful to them and their families. In 2000, only 18.9 percent of North Carolinians age 65 and older used hospice in the last year of life (*Last Acts* 2002a). This figure was lower than the national average of 21.5 percent and was one of many reasons Last Acts, the nation's largest coalition to improve end-of-life care, gave North Carolina a low grade in its first state-by-state report card on availability and use of care for dying persons. According to *Last Acts*, terminally ill North Carolinians have "mediocre to poor care at the end of life" (*Last Acts* 2002a). The state was rated high in one area concerning its policies on pain management, because it allows doctors to treat pain at end of life without undue scrutiny.

The NC End of Life Care (NCEOL) Coalition, housed in the Carolinas Center for Hospice and End of Life Care (2001), was formed in 1999 with funding from the Robert Wood Johnson Foundation to promote end-of-life services in the community. Today, the NCEOL includes 35 local end-of-life coalitions and has trained more than 450

health care professionals and community leaders. Its quality improvement project provides intensive education in pain management and end-of-life care for staff in nursing homes (*Last Acts* 2002b).

Strengthening Collaboration *between* Aging *and* Health Services

Promotion of healthy aging through increased collaboration between aging and health services is emerging as a major theme nationwide. Nationally, the CDC and the Administration on Aging (AoA) joined forces in 2002 to promote collaboration between aging and public health services. North Carolina is well placed in this effort. The two lead agencies in the state, the NC Division of Public Health (NCDPH) and NCDOA have a long history of collaboration on aging services that often includes other agencies and organizations in and outside state government. Within the NCDPH, the Older Adult Health Branch serves as a focal point for bringing together public health and aging interests in North Carolina. The branch is one of only a handful of programs in the nation dedicated to older adults' health issues within a state public health structure. As the state unit on aging responsible for the Title III-D Program for Health Promotion and Disease Prevention under the Older Americans Act, the NCDOA shares responsibility for expanding North Carolina's health promotion and disease prevention services for older adults, in collaboration with the Area Agencies on Aging (AAAs). In 2002, the two divisions successfully collaborated to receive one of the first grants from the Chronic Disease Directors Association, designed to foster and expand the state's health and aging partnerships. Additionally, as the principal collaborators on the CDC-funded North Carolina Healthy Aging Network initiative, the University of North Carolina's Institute on Aging and the Program on Aging of the UNC-Chapel Hill School of Medicine help link services, education, and research activities for health promotion and disease prevention for the state's seniors.

North Carolina has been steadily moving toward coordinated programming for disease prevention and health promotion activities, with special attention paid to major chronic diseases and vulnerable populations. For example, the NCDPH leads *Start with Your Heart*, a public awareness campaign to promote heart disease prevention through better nutrition and physical activity. The NC Cooperative Extension Service is collaborating with the NCDOA on the *Partners in Wellness* program, designed to reduce the risk of malnutrition among older adults with low incomes through nutrition education. The NC Senior Games conducts year-round health promotion and enrichment programs in all 100 counties for adults age 55 and older. One of the latest developments is a new partnership between the NCDOA and the NC Division of Social Services (NCDSS) to encourage older adults eligible for Food Stamps to use them to improve their nutritional status (with funding from the US Department of Agriculture). These are a few examples of the multifaceted activities within the NCDHHS focused on disease prevention, health promotion, and health education for today's seniors and those to follow.

More collaborative activities between aging and public health services are expected to take place locally during the next four years. There is an opportunity for integrated planning in connection with the local health departments' Community Health Assessment Process, the AAAs' local administration of the Title III-D programs, and health programs at senior centers. As part of the movement toward becoming state-certified Centers of Excellence, many senior centers are expected to increase their visibility in the community as a focal point for prevention services. According to a recent NCDOA survey (2002), 74 percent of senior centers have already established ongoing collaboration with local health departments, providing health screening, health education, and other health-related activities.

Priorities for Healthy Aging *in* North Carolina

1. NCDHHS will expand healthy aging education and training activities for older adults and their families, baby boomers, and health and aging services professionals.
2. NCDHHS will increase multifaceted, collaborative activities among aging, public health, and other services to make substantial progress in meeting relevant objectives established by the *NC Health Objectives for the Year 2010*.
3. NCDHHS will implement its plan to help eliminate health disparities among seniors.
4. NCDHHS will improve access to prescription assistance/medication management assistance services for older North Carolinians through major initiatives, including the NC Senior Care Program and Title III-D under the Older Americans Act.
5. NCDOA will lead an effort to examine the availability and adequacy of dental services for older adults and to develop strategies to improve access to prevention and treatment services.
6. NCDHHS will establish a statewide initiative to promote timely use of mental health services by older adults through collaboration between aging and mental health programs.
7. North Carolina will increase immunization rates for both influenza and pneumonia to 75 percent of all North Carolinians age 65 and older, with special focus on improving immunization rates among members of minority groups by 2010.
8. NCDHHS will continue to collaborate with public and private agencies and organizations to promote the importance of end-of-life care.

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3 Long-term Care and Aging

Supporting older adults and people with disabilities and their families in making their own choices about living arrangements and care

Major Accomplishments (1999–2003)

- ✓ North Carolina developed a *Long-term Care* (LTC) *Plan* at the request of the General Assembly.
- ✓ NC Department of Health and Human Services (NCDHHS) secured several federal grants, including "Real Choice," to help implement the *LTC Plan* and the state's *Olmstead* Plan.
- ✓ Under the 2000 Amendments to the Older Americans Act, the NC Division of Aging started the NC Family Caregiver Support Program.
- ✓ The General Assembly and the NCDHHS strengthened oversight of adult care homes by including those with seven or more residents under the Certificate of Need law [NCGS 131E-175 (9B)], adding staff to investigate complaints and using health professionals as regulatory consultants.

Current and Future Concerns

- ✓ Many of the *LTC Plan*'s recommendations for reform require funding.
- ✓ Federal grants help with testing innovations, reforms, and specific time-limited projects, but they cannot sustain these efforts.
- ✓ Aging of the population and economic uncertainty increasingly pressure family caregivers, who provide most long-term care.
- ✓ A number of issues pertinent to the quality of care in adult care homes, nursing homes, and home and community care settings remain. Response to many of these issues will require adequate funding.

"No set of issues related to the health of North Carolinians is more important or more complicated than those dealing with long term care for the state's older adults, people with disabilities, and their families." So concluded the NC Institute of Medicine's Task Force on Long-Term Care in *A Long-term Care Plan for North Carolina: Final Report* to the NCDHHS (cited as the *2001 LTC Plan* in this chapter; see NCIOM 2001, p. 1). The task force considered long-term care (LTC) to mean services and supports—paid and unpaid, provided in the home and community as well as in residential and institutional facilities—designed to assist adults with disabilities in living their lives to the fullest. Charged with developing a LTC system to provide a continuum of care (Chapter 237, Sec. 11.7A of the 1999 Session Laws), NCDHHS adopted the task force's *2001 LTC Plan* to guide its work. The recommendations of the task force have also helped North Carolina respond quickly to the 1999 *Olmstead* decision (*Olmstead v. L. C.* [98-536]), in which the US Supreme Court ruled that inappropriate institutionalization of a person with a mental disability may be discrimination under the Americans with Disabilities Act. This is a decision that has had wide-reaching implications for older adults and others facing care in facilities. The NCDHHS concurs with the task force's recommended policy statement for guiding future reform of the LTC system:

North Carolina's policy for long-term care is to support older adults and people with disabilities needing long-term care and their families, in

making their own choices with regard to living arrangements and long-term care services that will result in appropriate, high-quality, cost-effective care provided in the least restrictive setting.

To advance the LTC reform process in North Carolina, Carmen Hooker Odom, NCDHHS Secretary, formed the Office of Long-Term Care and Olmstead, created the position of Assistant Secretary for Long-Term Care and Family Services, and established a LTC Cabinet. Composed of division directors, the cabinet coordinates all LTC-related work across the NCDHHS, focusing on five areas:

1. improving entry into the LTC system
2. assuring statewide availability of core LTC services
3. addressing the severe shortage of direct care workers and other workforce issues
4. enhancing the quality of LTC
5. exploring creative approaches to financing LTC.

Early in the reform process in 2001, the NCDHHS secured a $1.6 million, three-year *Real Choice* grant from the federal Centers for Medicare and Medicaid Services (CMS). North Carolina was one of 23 states receiving the grant, the purpose of which is to address the crisis in recruitment and retention of direct care workers in home, community, and facility care settings. It also supports development of a model for consumer-directed care. This grant allowed the NCDHHS to move forward with a portion of the LTC reform plan, even while state and local budgetary challenges have slowed other implementation efforts considerably.

Demography and Long-term Care

Only about half of adults needing long-term care are age 65 and older. Although a landmark study by Manton and Gu (2001) reported that disability rates among older Americans have been steadily dropping in the past two decades (1.6 percent per year from 1989 through 1994, and 2.6 percent per year from 1994 through 1999), the growth in numbers of the older population by itself makes a compelling reason for LTC reform.

In North Carolina the population age 65 and older is projected to increase by 22 percent between 2000 and 2010. By 2030, our state's older population will have grown 129 percent from the 2000 baseline, compared to 55 percent for the total population. This increase will strongly affect the number of persons needing LTC, as 60 percent of the population 65 and older will need such assistance sometime in their lives. More importantly, the population most at risk—those age 85 and older—is expected to increase by 42 percent between 2000 and 2010 (NCOSBM 2002). It is estimated that the total number of persons in North Carolina with LTC needs will grow from 351,600 to 418,400 (19 percent) during this ten-year period (NCIOM 2001).

It will remain difficult for NCDHHS to implement many of the recommendations contained in the *2001 LTC Plan* until the state's budgetary outlook improves. Nevertheless, North Carolina cannot ignore the growing service needs of an aging population and the increasing pressure on the publicly funded service system. One purpose of this *NC Aging Services Plan* is to bring attention to pressing issues and to set goals to begin addressing them. The *Aging Plan* proposes that North Carolina:

- value families as the primary providers of LTC
- strengthen home and community care
- achieve and maintain quality services
- increase the ability of the state and counties to manage the cost of Medicaid
- apply consumer-directed care
- increase use of assistive technologies
- support personal and community LTC planning efforts.

Valuing Families

In a recent report of the US Senate Special Committee on Aging (2002), experts warned that our nation's LTC system is on the brink of crisis. National spending for LTC, at home and in facilities, was $137 billion in 2000. Medicaid paid 45 percent and Medicare paid 14 percent, with the balance covered out-of-pocket or through private insurance. LTC spending is projected to grow to $207 billion by 2020 and $346 billion by

2040 because of increasing numbers of users and the escalating cost of care. The committee concluded that supporting family caregivers is one of the most critical strategies in LTC reform.

Family caregivers are the key provider of LTC services nationwide, with at least 80 percent of the care for older adults given informally by family and friends. A survey of adult North Carolinians in 2000 (NCSCHS 2002) found that 17.1 percent had cared for a person age 60 or older during the previous month, which was higher than the national average (15.7 percent). While 19.6 percent of women identify themselves as caregivers, a significant number of men (14.3 percent) also provide caregiving. Almost half (47.3 percent) of these caregivers are between ages 45 and 64, including about one of every four persons (26 percent) between 45 and 54. Not surprisingly, the NC Division of Social Services (NCDSS 2003) found that family caregivers are very important in determining whether a person with disabilities is able to live at home instead of being placed in an adult care home. Eighty-four percent of the participants in the NCDSS's Special Assistance In-home Demonstration Project had family members as primary caregivers (NCDSS 2003).

North Carolina has a history of supporting family and friends caring for loved ones, as evidenced by the Respite Care Program established in the 1986 Regular Session. The creation in 2001 of the National Family Caregiver Support Program (NFCSP) under the Older Americans Act (OAA) presented an unparalleled opportunity of which North Carolina took full advantage. North Carolina is only one of five states (and the only southeastern state) chosen by the federal Administration on Aging (AoA) and the Lewin Group to be highlighted in the *2002 NFCSP Resource Guide*. The NCDOA was recognized for its successful partnerships, organizational structure, leveraging of resources, and creative programming (AoA 2002). In 2001, NCDOA also secured a three-year, $1 million federal Alzheimer's Demonstration grant to provide dementia-specific assistance and respite for caregivers.

Two priority recommendations in the *2001 LTC Plan* call for the NCDHHS to: (1) design its LTC policies and program activities to strengthen the capacity of families to perform caregiving functions; and (2) explore ways to invest in family caregiving so that it can be sustained as the primary resource for LTC, thereby reducing the need for formal, publicly financed services. Working through the Area Agencies on Aging (AAAs) and many other partners, the NCDOA has further developed these recommendations into four specific goals for the program:

- assure that every region has an effective Information and Assistance (I&A) system
- develop access to caregiver respite, counseling, and training in each county
- develop knowledge of the unmet needs of caregivers
- help to implement the *LTC Plan*, including increasing the availability of core services and strengthening local planning for aging and LTC.

The NC Progress Board acknowledged the value of caregiving by including in its *NC 20/20* report (2001) the goal that "North Carolina will have at least 10 comprehensive caregiver resource centers to provide support for family members caring for impaired older adults." With the Family Caregiver Support Program in place, the NCDOA and the AAAs are well positioned to take the lead in developing such centers as funding becomes available.

While there is no denying the importance of valuing family caregivers, this does not say that all persons have family, however defined, willing and able to assume this role. Thus, the *2001 LTC Plan* recognizes that guardianship and adult protective services are sometimes required to assure that LTC needs are met.

In North Carolina adults who no longer possess the ability to make decisions for themselves and/or their assets have the right to have qualified guardians appointed by the courts to help them make decisions and exercise their rights. The Clerk may appoint an individual (family, friends), a corporation, or a disinterested public agent to serve as guardian when family, friends, or corporations are not available to serve. Disinterested public agent guardians may be the director or assistant director of, for example, a county Department of Social Services (DSS), area mental health program, public health department, or county department on aging. The

NCDSS manages the NCDHHS disinterested public agent guardianship program. Data indicate that county DSSs continue to have the majority of the public agent guardianship appointments in the state. For example, county DSSs had approximately 74 percent of the total 2,468 public agent guardianship appointments during the third quarter of SFY 2002–2003, including 1,862 appointments for adults age 60 and older. County DSS directors have increased responsibility for guardianship services, although they receive no specific funding to support their activities in this program area. One of the reasons for this increased responsibility is the need by LTC facilities and hospitals to have someone with the legal authority to consent to placement and to approve medical treatment for those who are unable to make these decisions for themselves and do not have family members to assume this role. Because there has not been a comprehensive review of the laws governing guardianship in 12 years, the Study Commission on Aging recommended that the 2003 General Assembly establish a Legislative Study Commission to study state guardianship laws.

Under the Adult Protective Services (APS) program, county DSSs evaluate allegations that disabled adults are abused, neglected (including self-neglect), or exploited and in need of protective services. County DSSs evaluate reports involving adults living in domestic settings as well as facility settings, such as nursing homes. When a need for protection is found, services are provided with the disabled adult's consent or by a court order if the adult is not capable of consenting. In SFY 2000–2001, the number of complaints involving adults age 60 and older was 6,491, or 71 percent of all reports. Mistreatment in the form of abuse, neglect, or exploitation was confirmed in 36 percent of the reports, and the need for protective services was substantiated for 23 percent of the reports. Unfortunately, the services needed to protect the adult are not always available.

Strengthening Home and Community Care

Two basic truths about older adults are pertinent to any discussion of home and community services—most seniors live in the community and want to remain where they are, and many of those who live in care facilities hope to return home. In addressing the US Senate Special Committee on Aging (2002; see p. 10), some governors expressed frustration in having to apply for waivers for home and community care when nursing home care is an entitlement under Medicaid for seniors and younger people with disabilities.

In 2002, the Bush Administration launched a New Freedom Initiative to help states serve people eligible for Medicaid in private homes or community residential settings when they would otherwise require nursing facility care. In October 2002, the NC Divisions of Medical Assistance and Vocational Rehabilitation Services (NCDMA and NCDVR) received a three-year $600,000 Nursing Facilities Transition grant from the CMS. This initiative is designed to help willing and able residents of nursing homes return to the community.

Table 3. NCDHHS Expenditures for Persons Age 60 and Older by General Service Categories (Percent)

	State Fiscal Year		
Category of Services	97–98	99–00	01–02
Adult Care Home	5.7	6.2	6.5
Home and Community Care	13.0	13.8	15.5
Institutional Care	51.2	43.5	43.4
Other*	30.0	36.7	34.6

*This category includes economic supports (e.g., food stamps), health care (e.g., hospitalization, prescription drugs), and social supports (e.g., general transportation).
Source: NCDOA 2002

In recent years North Carolina has increased support of home and community care, as evidenced by the improved ratio of home and community care and adult care home expenditures to institutional spending, which is primarily nursing home care. This trend is shown in Table 3, which gives the percent of NCDHHS expenditures (federal, state, and required local match) for persons age 60 and older by general service categories (NCDOA 2002). In fiscal year 2001, North Carolina ranked 16th among states in the percent of its Medicaid LTC spending targeted for home care (37.3 percent, compared to the national average of 29.5 percent [CMS 2002]).

Still, a problem in helping people make the transition from facility to community care or to

remain at home is that most communities lack adequate resources to assist older persons and their families. This has been evident even among persons requiring APS. The NCDSS reports that in SFY 2000–2001, the specific service needed in the community had a waiting list in 40 substantiated APS cases. In another 43 APS cases, the service needed did not exist in the county where the adult lived. APS social workers anecdotally report that this sometimes results in disabled adults receiving more restrictive and more costly forms of protection (NCDSS 2003).

The availability of home and community services is integral to a community's ability to allow older and disabled adults to remain safely at home. There are indications that some communities across the state are becoming less able to support these services. For example, the availability of adult day services declined in 2002 when eight certified centers closed. In 2000, there were 125 centers in 68 counties; as of February 2003, there were 110 centers in 61 counties. This trend is also evident among nearly all of the services funded under the state's Home and Community Care Block Grant (HCCBG).

While HCCBG funds were not cut by the General Assembly during fiscal years 2001 and 2002, the lack of increased funding resulted in less service as operating costs grew. For example, 547 fewer seniors received in-home aide services in 2002 than in 2000, a 6 percent decrease, and there was also a 6 percent reduction in the number receiving home-delivered meals. Both are crucial services for helping seniors remain at home. As of January 2003, among the service providers, more than 11,400 seniors were waiting for services funded by HCCBG. This included over 4,150 needing home-delivered meals and over 5,235 waiting for in-home aide assistance. Also, fewer counties offered certain "core LTC services" under HCCBG in SFY 2002 than in SFY 2000. For example, only 36 counties chose to provide housing and home repair in 2002, while 41 provided these services in 2000.

Cost-containing actions taken with the Medicaid Community Alternatives Program, Medicaid Personal Care Services, and other programs have added pressure to HCCBG and other sources of home and community assistance. Concerned about a 64 percent increase in expenditures for personal care services covered under the state's Medicaid program between SFY 2000 and 2002, the General Assembly reduced the maximum number of service hours from 80 to 60 per month (S.L. 2002-126). A 23 percent increase in expenditures under the Medicaid Community Alternatives Program for Disabled Adults (CAP/DA) prompted the NCDHHS to freeze participation in October 2001, which resulted in 21 percent fewer recipients, even though the freeze was partially removed in fall 2002.

While these findings about Medicaid- and non-Medicaid-funded home and community care services are ominous, the use of State-County Special Assistance to support home care is a positive development. North Carolina has been one of the few states to limit Special Assistance to serving only people who live in *licensed* facilities. To examine expanded options available under this program, the General Assembly authorized a demonstration project (S.L.1999-237, Section 11-21) that allowed State-County Special Assistance to assist up to 400 persons who would otherwise require placement in a licensed adult care home. Based on two years of experience in serving 377 individuals in 22 counties, the NCDSS (2003) has concluded that providing Special Assistance payments to individuals to enable them to continue living at home is an effective approach for providing an alternative to adult care homes. The NCDHHS supports increasing the number of available slots in this project from 400 to 800 to allow additional counties to participate. An in-home component of the State-County Special Assistance Program is seen as an important part of the NCDHHS *Olmstead* Plan, along with such other programs and initiatives as CAP/DA and the Nursing Facilities Transition grant.

The success and value of home and community care depend largely on the informal, unpaid support of family and friends, and on the availability of adequate housing and transportation. Support of family caregiving and formal home and community services holds the most promise for sustaining LTC in the future.

Achieving and Maintaining Quality Care

While most people who need LTC live at home, others still require short-term or long-term stays in adult care homes, nursing homes, and mental health facilities. Wherever care is provided, its quality is important to assure both the safety and well-being of the recipient. As the NCIOM Task Force on Long-Term Care found, *quality* is not a straightforward concept.

Because the quality of care is so dependent on the availability of trained paraprofessionals, the NCDHHS is emphasizing efforts to address the severe shortage of direct care workers. Particular attention is paid to the high turnover rate for nursing assistants (approximately 100 percent during each of the past three years in nursing homes, and even higher in adult care homes).

Achieving and maintaining quality LTC services requires a multifaceted approach. In addition to focusing on workforce issues, a few areas that warrant particular attention are:

- The General Assembly has acknowledged that Medicaid reimbursement methodologies for LTC services must set rates that enable providers to comply with certification requirements, licensure rules, and other mandated quality and safety standards [S.B. 1115, Section 10.19A (Session 2001)].
- There is a need to maintain adequate staff capacity in the regulatory, ombudsman, and consultation services to inform providers of best practices and resolve problems.
- Further examination of issues that affect the quality of life of older adults receiving LTC is warranted. For example, the NC Division of Facility Services (NCDFS) proposes to study the merits of regulations that address concerns about the safety of older residents in adult care homes also housing young residents with mental illness. In addition, the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NCDMH/DD/SAS) plans to establish at least two 20-bed Enhanced Behavioral Care units in nursing facilities to provide specialty services for people who are currently being served in certified nursing units in state hospitals. This initiative will begin in the Goldsboro area to serve long-term geriatric residents of Cherry Hospital, one of the state's four psychiatric hospitals. Furthermore, NCDMH/DD/SAS anticipates establishing geriatric teams at newly formed Local Management Entities to provide communities with specialized services, technical assistance, and consultation related to the needs of the older adult population.

Managing Medicaid Statewide

Medicaid has accounted for at least 8 of every 10 public dollars (federal, state, and required local match) expended by state agencies for services to adults age 60 and older since SFY 1995–1996. Many of these costs are tied to LTC, including the mandated funding of nursing home care and home health services, and such optional services as personal care and hospice care. For SFY 2001, Medicaid support of LTC for older and disabled persons totaled about $2 billion, an increase of 8.7 percent over the previous year. This equaled about 37 percent of the total Medicaid service expenditures (NCDMA 2002).

Total Medicaid expenditures for older North Carolinians increased from $1.4 billion in SFY 1999 to $1.7 billion in SFY 2001, about 22 percent (NCDMA 2002). For the same period, the number of older Medicaid recipients grew by about 16 percent. In SFY 2001, older adults represented 14 percent of people eligible for Medicaid, 14.9 percent of recipients, and they accounted for 31 percent of service expenditures. The projected increase in number of older adults is one of the reasons why fiscal responsibility for North Carolina's Medicaid program is an emerging issue.

For FFY 2003, the federal government will pay about 62.56 cents of each Medicaid dollar, up from 61.46 cents in FFY 2002. This is the first increase in the federal medical assistance percentage (FMAP) in more than 17 years and reflects the decline in North Carolina's per capita income relative to the national figure (Saxon 2002).

As one of 10 states that require counties to share in the nonfederal cost of Medicaid, North Carolina counties must currently pay 15 percent of the nonfederal share, or about 5.6 percent of the total cost, of Medicaid payments on behalf of county residents. In addition, counties must pay

nearly all the nonfederal share of local administrative costs.

Not surprisingly, some counties are especially burdened by their Medicaid obligations. For example, Robeson County spends nearly 26 cents on Medicaid for every $100 of its property-tax base, while Dare spends just 1.4 cents. Partly because of these discrepancies among counties, several bills were introduced during the recent General Assembly's legislative session to eliminate or reduce the responsibility of counties for supporting Medicaid. The NC Association of County Commissioners is encouraging continued consideration of such proposals, including some that would reduce the burden for at least the most economically distressed counties (Saxon 2002). Regardless of whether counties receive relief from their Medicaid fiscal responsibility, the growing costs of Medicaid in a time of budgetary shortfalls could lead to changes in eligibility; further efforts to control utilization; or statewide reduction in or elimination of such important optional services as personal care, prescription drugs, dental services, eye care, mental health services, and hospice.

The General Assembly's interest in improving the administration of CAP/DA (S.L. 2002-126 [S1115] Section 10.16) is an example of how the state is examining ways to manage Medicaid costs better. Among the changes recommended by the NCIOM (2003) in its study of the CAP/DA program were:

- a more thorough assessment to determine level of care and eventually enable a case-mix payment system
- creating a work group of interested organizations to explore alternative service delivery and payment methodologies that could lead to improvements in care to individuals and potentially lower per capita costs in the CAP/DA program.

Applying Consumer-Directed Care

During the past few years, interest has grown nationally and in North Carolina in what is popularly called *consumer-directed care*. Consumer direction is a philosophy and program orientation that accommodates the needs and preferences of consumers by offering them choice of and control over services, service providers, and delivery mechanisms.

Part of North Carolina's *Real Choice* grant includes a provision to develop one or more models of consumer-directed care for older and disabled adults. This effort is being aided by the NCDHHS's Community-Personal Assistance Services and Support (PASS) grant, which will assess relevant fiscal and regulatory policies in terms of their support of consumer-directed care and help prepare providers to offer such care. While the service system for younger disabled persons, especially those with developmental disabilities, has considerable experience with this approach, consumer-directed care would represent a substantial change for much of the aging services system. In March 2002, the NCDOA was one of five state agencies nationwide to secure a small grant from the National Association of State Units on Aging to begin, with help from consumers and policymakers, a process of determining how consumers might have increased opportunities to make choices and direct their own home and community care.

If successfully implemented, consumer-directed care can help in a number of ways. For example, it may be easier for families to care for their loved ones at home, thus decreasing the need for direct care workers in institutions. The NCDOA is actively working on a reform agenda for consumer-directed care through further development of a statewide, comprehensive system for Information and Assistance (I&A) and the expanded use of vouchers in the Family Caregiver Support Program.

Using Assistive Technology

People of all ages with or without disabilities are living longer. Some bring to their later years acquired long-term disabilities. Others develop disabilities in later life. While advances in medical technology have helped secure increased longevity, other technologies are helping people better cope with physical, sensory, and cognitive impairments, allowing them to continue to live at home with more independence.

Assistive technology is defined as any item used to maintain or improve the functional abilities of an individual. Unfortunately, the poten-

tial of such technology is largely unrealized for many seniors. Assistive technologies of all types, including such low-tech and low-cost devices as canes, manual wheelchairs, and communication boards, are used by only a small fraction of persons who might benefit from them (Campbell 2001). Older adults are also significantly less likely to use such higher-tech devices as electric wheelchairs and scooters. While affordability can be an issue, the lack of awareness among seniors and service providers about what exists, how it can be secured, and how it might be of benefit is the major factor.

North Carolina has an opportunity to make a marked difference in this area through collaboration in the education and training of seniors, family caregivers, and formal service providers. This will involve a close working relationship among those NCDHHS divisions that can most contribute in identifying both applicable technologies and target populations. The NC Division of Vocational Rehabilitation (NCDVR) offers the NC Assistive Technology Program (NCATP) and provides statewide free assistive technology services to people of all ages and abilities to increase independence and quality of life in everyday living. Other divisions with strong interest in this area include Aging, Services for the Blind (NCDBS), Services for the Deaf and Hard of Hearing (NCDSDHH), NCDSS, and NCDMH/DD/SAS. Effective use of technology, combined with modifications in the home and community environments, are consistent with and supportive of consumer-directed care, family caregiving, and greater use of home and community-based care.

Increasing Personal and Community Planning

LTC reform will only be successful to the extent that individuals, families, and communities undertake thoughtful advance planning and strategic action. Progress in reforming LTC will require further education and effective public policy. As an example of progressive action, North Carolina is one of 18 states offering tax incentives to individuals or employers to purchase long-term care insurance policies. In 2002, the federal government began to sponsor such insurance coverage for its workers. (The importance of personal planning for LTC is discussed in the chapter on economic security.)

While acceptance of personal responsibility for LTC is important for individuals and their families, as well as for the state and its taxpayers, state and community planning and public policy reform are also essential to assure judicious use of available public resources. The recommendations being prepared by the NCIOM, at the request of the General Assembly and the NCDHHS, to improve the administration of the CAP/DA program illustrate the importance of both planning and public policy reform.

In North Carolina, as in most other states, a variety of barriers to establishing coordinated, client-centered LTC systems exist. Uncoordinated health and human services planning and the lack of useful information are two such obstacles. Across the state, a variety of entities are responsible for planning different aspects of LTC services for older and disabled adults. These include CAP/DA advisory committees, AAAs and local HCCBG committees, Social Service Boards, Area Mental Health Boards, Healthy Carolinian Task Forces, and County Health Departments' Community Health Assessment process (a process involving a wide range of stakeholders within the community). As the NC Association of County Commissioners has aptly noted, "Planning for long-term care services in many counties is more accidental than by design [, which] can result in costly duplication of services" (2002; p. 1).

A priority recommendation of the *2001 LTC Plan* is that "the General Assembly should encourage county commissioners to designate a lead agency to organize a local long-term care planning process at the county or regional level" (p. 58). The *Plan* also recommends that "the Department should develop county data packages and provide technical assistance to the counties to assist them with their long-term planning process" (p. 58). The General Assembly, in Section 22.1 of the Studies Act of 2001 (S.L.2001-491 [S166]), directed the NCDOA to "study whether counties should designate local lead agencies to organize a local long-term care planning process." While the division concluded that local planning is important, it also recognized that such planning as described in the

2001 LTC Plan requires resources and should not be imposed as an unfunded mandate. The NC Study Commission on Aging agreed and recommended that the 2003 General Assembly fund a pilot project on LTC local lead agencies to support community planning.

Seeing the importance of planning for LTC as essential to the achievement of many of the other changes recommended in the *2001 LTC Plan*, the NCDHHS LTC Cabinet has proposed creation of "A Communications and Planning Network to Support Families in Their LTC Roles." This network would connect state and local interests committed to LTC planning to achieve the following objectives:

- pilot test and replicate county planning processes and tools to evaluate core LTC services and develop strategies for reforming local LTC systems
- foster innovative approaches to LTC service delivery through enhanced cooperation among providers and with increased consumer input
- link local findings to state policy and program development bodies to inspire a joint commitment to action toward a more efficient, coordinated, and adequate LTC system.

Support of local LTC planning is not only important for implementation of the *2001 LTC Plan*, it is also vital to the state's response to the *Olmstead* decision. Persons with chronic illnesses and disabilities require assistance over a prolonged period of time, as do their family caregivers. With growing numbers of seniors, North Carolina must act now to minimize future public costs of LTC and assure an LTC system that is responsive to the needs and interests of consumers.

Priorities for Long-term Care *and* Aging *in* North Carolina

1. NCDHHS will support increased access to home and community care, including HCCBG funds targeted to low-income older adults who are not eligible for Medicaid. Additionally, NCDHHS supports expanded enrollment in Medicaid CAP/DA and a phased expansion statewide of the State-County Special Assistance In-home initiative. Realistically, increasing access will require efficient use of existing funds as well as additional funding when this becomes possible (see Appendix B for related activities identified by NCDHHS agencies).
2. NCDHHS will continue work stimulated by *Real Choice*, including taking steps to strengthen the direct care workforce, piloting one or more models of consumer-directed care that include older participants, and implementing the Nursing Facilities Transition grant.
3. NCDHHS will increase collaborative activities among NCDOA, NCDSB, NCDSDHH, NCDVR, NCDSS, and other divisions and offices to educate seniors and family caregivers about disabilities and how to cope with functional losses.
4. NCDOA will continue its work with many partners toward development of a multifaceted system of supports for family caregivers.
5. NCDHHS will pilot a Communications and Planning Network to Support Families in their LTC Roles, to support local LTC planning with volunteer counties.
6. NCDSS will ensure the quality and accountability of its protection of vulnerable older adults by strengthening standards for Adult Protective Services (APS) and promoting a consistent and collaborative approach to the delivery of guardianship services.

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4 Economic Security

Supporting the economic well-being of older adults and the economic security of aging boomers

Major Accomplishments (1999–2003)

- ✓ In 1999, North Carolina expanded Medicaid coverage to include older adults age 65 and older with incomes below 100 percent of the poverty level.
- ✓ In 2002, with funding from the Health and Wellness Trust Fund Commission, the NC Department of Health and Human Services (NCDHHS) implemented the *NC Senior Care Program* to provide prescription drug assistance to seniors with low incomes for the treatment of chronic obstructive pulmonary disease (COPD), cardiovascular disease, and diabetes.
- ✓ North Carolina was nationally recognized for helping dislocated workers (including many older workers) access assistance from the North American Free Trade Agreement (NAFTA)/Trade Readjustment Allowance (TRA).

Current and Future Concerns

- ✓ Over 337,000 (36 percent) of older North Carolinians are considered poor or near poor (within 200 percent of the poverty level).
- ✓ Without a federal initiative, many seniors will continue to lack adequate drug assistance and long-term care protection, requiring the state to respond.
- ✓ A part of the Medicare-Aid program, which helps seniors with low incomes pay for Medicare premiums, has an uncertain future without reauthorization of the Balanced Budget Act of 1997, and over 11,000 North Carolina seniors may lose benefits.
- ✓ 15 percent of North Carolinians between ages 50 and 64 are uninsured.
- ✓ Many retirees and workers lack knowledge and skills for financial planning and management.

The nation's economy has experienced both historic highs and sharp downturns within the past several years. Today, the economy remains sluggish, and its future course unclear. In this economic environment, seniors are increasingly concerned about their economic security. This concern is also felt strongly among the baby boomers as they approach age 62, the most common age when older adults start receiving Social Security benefits (AARP 2001).

The NC Division of Aging (NCDOA) convened a focus group in July 2002 to identify economic issues concerning older adults and baby boomers today and to help set priorities for the future. The focus group considered the term *economic security* in objective and subjective terms and broadly defined it as *the capacity to sustain a relatively stable economic status given a normal decline of functioning and health over old age* (O'Rand 2002). This view was well expressed by a senior advocate: "In my opinion, we seniors are economically secure when we are free from fear or doubt about our ability to pay for necessities such as health and long-term care expenses, housing, and leisure and enrichment activities."

In its long-range plan, *Vision 20/20,* the NC Progress Board (2001) declared North Carolina's commitment to realizing economic security for all North Carolinians through strong partnerships among individuals, the young and old, employers, and government. Consistent with the Progress Board's declaration, a call for action for older adults and baby boomers asks:

- individuals to embrace the idea of lifelong training and education to remain productive members of the community and to plan for retirement security in a responsible manner

- employers to treat older workers fairly, provide benefit programs to meet the diverse needs of their workers in preparing for retirement, and expand opportunities for job training and financial planning
- government to assure that laws and regulations, policies, and programs support the overall economic security of older adults.

As perceived by the NCDOA focus group, the economic security of older North Carolinians and aging baby boomers revolves around three major areas:

1. managing health and long-term care costs
2. maximizing older adults' productivity
3. improving individuals' capacity to manage their financial responsibilities through information, education, and planning.

This chapter discusses the issues and programs pertaining to these three areas. Because the economic security of seniors in North Carolina is most commonly measured by poverty, this is where the discussion must begin.

Poverty among North Carolina's Seniors

North Carolina continues to have a relatively high rate of poverty among older adults. The 2000 Census reported that for 1999 the state's poverty rate for adults age 65 and older was 13.2 percent, compared to the national rate of 9.9 percent. In contrast, North Carolina's overall poverty rate, 12.4 percent, parallels the national average of 12.3 percent (US Census Bureau, 2002, SF3, Table DP-2).

In North Carolina, Social Security keeps all but a few seniors (3.6 percent) from being among the "extremely poor" (up to 50 percent of the poverty threshold), but a disproportionate number of older adults—36 percent—are found among the poor and "near poor," (within 200 percent of the poverty threshold) (NCDOA 2002a). The high concentration of near-poor older North Carolinians parallels the national trend and highlights the economic dilemma of many seniors. They are not poor enough to be eligible for public assistance, yet they lack enough income to pay for such necessities as prescription drugs and utilities. For comparison, among adults ages 35 to 64, the proportions falling below 50, 100, and 200 percent of poverty were 3.8, 8.3, and 21 percent, respectively (NCDOA 2002a).

Concerned that the official US government poverty calculation might not sufficiently reflect today's economic reality, the National Academy of Sciences (NAS) and others have developed additional methods to calculate poverty rates. In their estimation, the poverty rate for adults age 65 and older was 14.5 percent nationally, compared to the official rate of 10.2 percent for 2000 (US Census Bureau 2001). The US Census Bureau notes that NAS's alternate method of calculating health care costs is a major explanatory factor for this difference.

Because of the vulnerability of seniors living in or near poverty and the risk facing baby boomers who lack sufficient resources to prepare for an economically secure retirement, North Carolina must tackle issues and undertake initiatives that have the best chance of making a difference. These measures include reducing the economic burden of health care costs on older adults, assisting older adults maintain their competitiveness in the labor market, and promoting financial planning and education for older adults.

Managing Health and Long-term Care Costs

The rising cost of health and long-term care has become a major threat to the economic security of many seniors and their families. Although the burden is particularly heavy among older adults in the near-poor category, older adults and baby boomers in better financial circumstances are also concerned that the high costs associated with their future health and long-term care might leave them impoverished. The current and future challenge of managing personal and public health budgets depends largely on what happens to Medicare and Medicaid and what progress is made to address the costs of prescription drugs and long-term care.

Medicare

Medicare is a federally administered health insurance program, designed largely to serve older adults. In North Carolina, 94 percent of adults age 65 and older are enrolled as Medicare beneficiaries today (MRNC 2001). A small proportion of older adults without Medicare

coverage has access to other health insurance programs. Primarily because of Medicare and Medicaid, less than 1 percent of older North Carolinians are uninsured, compared with the 15 percent uninsured (178,000 people) among those between ages 50 and 65 (Silverman et al. 2001).

The major concern among Medicare beneficiaries is the program's failure to cover certain health and long-term care costs. The major services *not* covered under Medicare include outpatient prescription drugs, vision care, hearing services, dental care, and long-term care. Beneficiaries also pay out-of-pocket to meet substantial cost-sharing requirements for the covered services. According to AARP (2002), in 2000 Medicare paid more than half (51.4 percent) of total health care costs for beneficiaries age 65 and older. The remaining costs were paid mainly by Medicaid (12.9 percent), private insurance plans (10.6 percent), and by the beneficiaries themselves (20.5 percent). The out-of-pocket expenditures would have been higher if Medicare premium payments were included, according to the same report.

The majority of older North Carolinians are enrolled in the Medicare fee-for-service plan (i.e., the "Original Plan") as their only health insurance and, consequently, are considered underinsured because of their limited coverage. For this reason, in North Carolina, about 40 percent of the beneficiaries enrolled in the Original Plan also have a Medigap policy (i.e., Medicare supplement insurance) sold by private insurance companies to help pay health care costs that Medicare does not cover (NCDOA 2002b). Beneficiaries having Medigap coverage are projected to spend an average of $3,250 per year on health care, in part because of the cost of Medigap premiums, according to AARP (1999).

In order to contain overall program costs and reduce beneficiaries' out-of-pocket spending, in 1999 Medicare initiated a Medicare Managed Care option under the new Medicare+Choice initiative. As of January 2003, this option is available in only 25 counties in North Carolina.

Medicaid

The Medicaid program is the principal medical safety net for older adults. In fiscal year 2001, 195,307 older Medicaid recipients averaged $8,687 in services that would have otherwise been the responsibility of individuals and their families, according to the NC Division of Medical Assistance (NCDMA 2002a). The value of this assistance for people at or below the poverty level highlights the struggle of the near-poor (up to 200 percent of poverty) to pay their own way on annual incomes of $8,592 to $17,184.

Unlike Medicare, Medicaid programs vary from state to state in eligibility criteria and covered services. In North Carolina, total Medicaid expenditures for older adults increased from $1.4 billion in 1999 to $1.7 billion in 2001 (NCDMA 2002a). In 2001, 44.9 percent of the Medicaid cost for seniors was associated with nursing home care, a required Medicaid service. This was down from 50.7 percent in 1999, while the proportion for the Community Alternatives Program for Disabled Adults (CAP/DA) and Personal Care Services (PCS), two optional services, grew from 8.1 percent and 3.7 percent in 1999 to 8.7 percent and 4.8 percent in 2001, respectively. Expenditures for prescription drugs, an optional service, also showed a substantial proportionate increase from 13.9 percent in 1999 to 18.9 percent in 2001.

Facing increases in Medicaid at a time of budgetary constraint, discussions to curtail costs have focused on changing client eligibility criteria, limiting optional services, and containing reimbursement to providers. Having celebrated the expansion of Medicaid coverage for older and disabled clients to 100 percent of the poverty level in 1999, there has been little interest in returning to a stricter eligibility level. This reluctance has left the state to consider and sometimes undertake such other actions as freezing CAP/DA in 2001. While the freeze was eventually lifted, in October 2002, CAP caseloads were still only about 73 percent of the pre-freeze level (NCDMA 2002b). In its 2002 short session, the NC General Assembly directed the NC Institute of Medicine (NCIOM) to conduct a comprehensive study of CAP/DA, with the goal of serving the maximum number of people within the budgeted appropriation. In addition, the 2002 General Assembly modified the transfer of asset policy for persons receiving Medicaid PCS and also reduced the monthly PCS limit from 80 to 60 hours. The General Assembly had considered

but did not eliminate support for other optional Medicaid services such as dental and eye care. Likely outcomes of such changes would have been diminished access to services and/or greater out-of-pocket costs for clients.

Pressure on the state and counties to control the cost of Medicaid will only build as the number of eligible older adults grows. In the coming years, the state will be forced to identify new ways of encouraging personal responsibility for North Carolinians to stay economically secure and, at the same time, helping those who are not secure to manage their health and long-term care costs. In this vein, greater participation by seniors in Carolina ACCESS, the Medicaid managed care program, is one approach that must be further explored. To date, only a small percentage of older Medicaid recipients opt to be enrolled in ACCESS, compared to 69 percent participation among younger Medicaid recipients. One reason for this low participation rate among older adults is the federal regulations prohibiting the states from limiting the choices for clients eligible for both Medicare and Medicaid. Also, by federal law, Medicaid recipients who are in long-term care facilities are not enrolled in any managed care plan. In light of early data indicating both the cost-effectiveness and improved quality of care for ACCESS enrollees (NCORDRHD 2001), the state must continue educating older Medicaid recipients about the benefits of enrolling in ACCESS.

Older Medicare beneficiaries with incomes between 101 and 175 percent of poverty are eligible for the Medicaid program called Medicare-Aid, designed to pay for Medicare Part B expenses such as premiums, deductibles, and coinsurance. This program was fully funded under the Balanced Budget Act of 1997, but a part of the program, called the Limited Medicare-Aid Capped Enrollment (MQB-E), had a sunset date of December 31, 2002. MQB-E pays the Medicare Part B premium for Medicare beneficiaries whose income was between 120 percent ($886 for an individual and $1,194 for a couple in 2002) and 135 percent ($997 and $1,344, respectively) of the poverty level (NCDMA 2003). In North Carolina, over 11,000 Medicare beneficiaries receive the MQB-E assistance, funded through a congressional continuing resolution since January 1, 2003. The current MQB-E recipients and others in similar economic circumstances will face difficulties meeting the Medicare premium payments ($704.40 annually in 2003) covered under this program if Congress does not take action to reauthorize the act. Approximately 25,000 additional Medicare-Aid recipients who meet the more stringent income limits set for two other programs, MQB-Q and MQB-B, are not affected by the sunset provision.

Prescription Drug Assistance

With no new major federal prescription drug assistance program in place, in 2001 North Carolina announced the expansion of its state prescription drug assistance program for low-income seniors who are not eligible for Medicaid. Under the *NC Senior Care Program*, launched in 2002, the Health and Wellness Trust Fund Commission (HWTFC) made a total of $96 million available over three years from the tobacco settlement funds to cover a portion of the costs for prescription drugs needed for treatment of chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), and diabetes mellitus (NCORDRHD 2002). As the latest development, the NCDHHS submitted a Medicaid waiver application in early 2003 to expand the NC Senior Care program to include all diseases. Funding from the HWTFC would be used to cover the state match required to access federal funds upon approval of this waiver request.

In addition, a number of major pharmaceutical companies expanded their medication assistance programs by offering various discounts to seniors. Because of the potential for confusion owing to the differences in eligibility and benefits among these programs, the NC Senior Care Program also supports medication education and review initiatives to aid consumers. While NC Senior Care and the private discount programs are helpful to seniors who meet their eligibility criteria, these programs still leave many without adequate assistance, given the rising costs both of prescriptions and over-the-counter drugs.

Financing Long-term Care

In 1999, North Carolina spent $1.3 billion on publicly funded long-term care services for adults age 60 and older, with more than two-thirds of the expenditures on institutional care

(NCIOM 2001). This figure represents an increase of 173 percent since 1990. Over the period, the number of adults age 60 and older increased by about 19 percent. In 2001, the NC Long-Term Care Task Force urged the NCDHHS to maximize use of federal dollars to fund long-term care services by ensuring that Medicare pays covered services for people eligible for Medicaid. In the 2002 short session, the General Assembly stipulated that NC Medicaid would cover care of eligible nursing home residents only after appropriate services had been billed to Medicare. The Task Force also recommended a number of measures to expand public funding of long-term care services (especially Medicaid) to ensure the equitable distribution of the funds and to reduce bias toward institutional rather than home and community care within the current system.

Over the past few years, the General Assembly has directed the NCDHHS to examine ways to expand private financing options for long-term care services. The Senior's Health Insurance Information Program (SHIIP) of the NC Department of Insurance (NCDOI), along with the NCDOA and AARP, have led efforts to inform and educate the public about the risks and costs of long-term care and to promote the state and federal incentives available for North Carolinians purchasing long-term care insurance. The federal incentive involves a tax deduction if medical and long-term care expenses exceed 7.5 percent of income under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. In North Carolina, the General Assembly established an individual state income tax credit of 15 percent of the premium costs of a federally qualified LTC insurance policy, up to $350. The state's tax credit, which began January 1, 1999, will expire January 1, 2004, unless extended by the General Assembly. As of tax year 2000, almost 30,000 North Carolinians had taken advantage of this provision. To a large extent, the low use of the tax credit reflects the low long-term care insurance penetration rate (1 percent of adults age 35 and older) in North Carolina (NCDFS 2000). In North Carolina, the typical profile of the tax credit claimant appears to be an older adult with taxable income less than $30,000, claiming a $200 credit. Long-term care insurance holders, as exemplified in this profile, may provide some relief to the state if in the next 10 to 20 years the insurance benefits help them avoid becoming Medicaid recipients. The annual cost of nursing home care, now around $52,000 on average for a semiprivate room occupancy (Metlife 2002), is projected to climb to $191,000 by 2030 (US Senate Special Committee on Aging 2002). However, the state's long-range goal must remain focused on attracting more baby boomers and even younger persons to accept personal responsibility for protecting against the enormous cost of long-term care. Reflecting the commitment to promote the use of long-term care insurance, both North Carolina and the federal government now have optional LTC purchase programs available for their employees.

Maximizing Older Adults' *Productivity*

Many older adults contribute to the state's economy as members of the paid workforce. In 2001, about 557,000 (301,000 men and 256,000 women), or 34 percent, of the North Carolinians age 55 and older were in the labor force, representing about 14 percent of the state's total workforce (US Bureau of Labor Statistics 2002). Among men ages 55 to 64, the national labor force participation rate has increased modestly since 1994, reaching 67.2 percent in 2001 (Fullerton 1998). For men age 65 and older, the rate has remained stable in the 16 to 18 percent range since the mid-1980s. Over the next 10 years, modest increases are expected for men in both age groups. For female workers ages 55 to 64, the labor force participation rate was reported at 52.9 percent in 2001 and is expected to increase by another 10 percent by 2015. The labor force participation rate among women age 65 and older was 10.7 percent in 2001 and is expected to remain constant. For many older persons, employment is an important way to stay engaged in the community; for many more, it is an economic necessity for both the earnings and the benefits offered through pension and health insurance plans (AARP 1999).

North Carolina's older workforce is diversified, ranging from highly skilled professional workers to those who never finished high school and work at minimum wage. Some of the issues facing older workers are common, regardless of their circumstances, while other issues are specific to certain groups. Issues of particular importance to older North Carolinians and baby boomers today are discussed below.

Vocational Training and Age Discrimination

Of all the types of discrimination complaints that the Equal Employment Opportunity Commission receives, age bias is showing the greatest increase (CD Publications 2002). Complaints typically concern hiring, firing, repeated verbal abuse, and demotion. Discrimination is also evident in terms of opportunities for training. A national survey of employers in the US found that companies were less likely to spend a substantial amount on the training of workers age 50 and older (Barth 1993). Today, a common belief persists within the business community that investing money in older workers is not cost-effective, because they will not stay with the employer long enough to provide sufficient return on the investment (Encel 2000). On the other hand, vocational training for older workers has been successfully implemented as an integral part of labor market policies in countries such as Canada, France, Germany, Japan, and Sweden (ILO 1995).

Today, much of the publicly supported job training in North Carolina is offered through the community college system. The state is nationally recognized for its excellent community college system, which offers two highly successful programs, the New and Expanding Industries Program (NEIP) and the Focused Industry Training (FIT) Program. However, many older workers—especially those without a high school education—will not pursue these community college programs without encouragement and supportive services. Even when job training is available, older workers are found among those less likely to participate, and they often express fears about returning to school for additional skill training (Watt 2001).

Bridge Work

Older workers with Social Security benefits and/or private pensions often express a preference for less than full-time work (e.g., working part time or on contingent basis). On the other hand, many older people displaced by plant closings or corporate restructuring seek but are unable to find full-time employment. Others involuntarily move to part-time employment owing to deteriorating health or the need to provide health care to family members. Employment in this transitional period between full-time work and full retirement is often referred to as *bridge work*. According to Rix (2001), as many as half of eventual retirees experience some form of bridge employment. However, rarely are these bridge jobs the result of formal phased retirement programs. An introduction of formalized bridge work within companies would be an important step forward for employers to keep valued employees and, at the same time, allow employees to ease into retirement in a secure and familiar environment. Moreover, it is likely to be increasingly important in the future to offer more flexible work options because declining sizes of the entry cohorts to the workforce are predicted to lead to shortages of qualified workers.

Workforce in Poverty

There are over 269,000 North Carolinians, constituting 16.4 percent of the population age 55 and older, living at 125 percent of the poverty threshold or below (NCDOA 2002a). Approximately 32.4 percent of them (93,000)—many women and/or minority group members—are estimated to be in the labor force (NCDOA 2002c). Through the federal Senior Community Service Employment Program (SCSEP), North Carolina offers job training and employment in all 100 counties to older workers at this income level who also have poor employment prospects. North Carolina's SCSEP, which is funded through Title V of the Older Americans Act (OAA), assisted about 2,200 workers in 2001 (NCDOA 2002d). An expansion of this and other programs designed to help older workers with low incomes become more competitive in the labor market represents an urgent need in North Carolina.

Older Dislocated Workers

In North Carolina, employment in manufacturing industries (e.g., textile, apparel, and furniture) has declined significantly in the past few decades as a result of automation and international trade, as well as cyclic economic downturns (NCESC 2001). The US Department of Labor (2002) ranked North Carolina among the top six states in layoffs in 2001. The changing economy in North Carolina has greatly affected older workers, reflected in the increasing number of unemployed workers age 55 and older seeking job search assistance through the NC Employment Security Commission: from 29,072 applications in 1999 to 41,503 in 2001 (NCESC 2002). Today, older workers who spent most of their life earning a good income in a mill or factory that is closing are likely to learn that their

skills and work experiences will not get them a new job (NC Commission on Workforce Development 2002). Several factors make older workers particularly vulnerable, including inadequate education, narrow work experience, higher rates of illiteracy, lack of adequate job training opportunities, barriers to relocation, and lack of access to convenient transportation services. Future work of the NC Commission on Workforce Development and the JobLink Career Development Centers, created in 1995, will be vital to the skill development and counseling necessary for incumbent and dislocated workers to make the transition to new jobs.

Improving the Financial Ability of Individuals through Information, Education, and Planning

Today, the notion of living on "fixed" or "guaranteed" retirement income is becoming rapidly obsolete, and many older adults are finding that an increasing portion of their income and assets depends on choices they make in the market economy. In the booming times of the 1980s and 1990s, many older adults and baby boomers took advantage of investment opportunities through their retirement benefit plans and other stock ownership programs, which increased retirement savings beyond normal expectations (AARP 2001). However, with the current economic recession and stock market downturn, many older adults and boomers have soberly realized that they lack the knowledge and skills necessary to plan successfully for retirement. Experts point out that the need for long-range financial planning is more evident now than at any other time (AARP 2001, Clark 2002).

Continuing education programs at universities and community colleges, retirement preparedness sessions offered through employers, and special programming at senior centers and other service organizations are but a few examples of current training opportunities, but they are not yet widely available, nor are sufficient numbers of people taking advantage of them. An example to improve access to financial services for seniors is the AAA effort at Region I in partnership with other stakeholders to develop a money management education and assistance program, using the AARP model, with a focus on vulnerable older adults. The importance of financial education and planning is discussed below with respect to three important sources of retirement income: Social Security, pensions, and (for older adults with low-income) public assistance.

Social Security

In North Carolina, about 92 percent of older adults age 65 and over receive Social Security benefits (NCDOA 2002e). According to the Social Security Administration (SSA; 2001a), older adults receive 38 percent of their total income from Social Security, making it the largest source of income for this population. The major controversy surrounding Social Security today is its long-term solvency. According to projections made by the SSA (2001b), the amount of the benefit payments will start exceeding tax income in 2016. By 2038, Social Security is projected to be able to meet only 72 percent of the benefit payments. The current proposals to extend the financial integrity of Social Security fall into two basic groups: those which would retain the current structure while making incremental changes to balance expenditures and revenues; and those which would remake Social Security to provide a basic benefit for everyone but require the future beneficiary's personal involvement in managing how some portion of the funds are invested.

Another significant factor in retirement planning involves the age at which older adults start receiving Social Security benefits. Nationally, 72 percent of older beneficiaries start receiving benefits prior to age 65 at reduced rates. Women (75 percent) are more likely to receive reduced benefits than men (69 percent), according to AARP (2001). This trend appears contrary to the gradual delay in the Social Security's eligible age with full benefit to 67.

Pensions

The extent of pension coverage has barely changed over the past two decades. According to the Survey of Consumer Finances, 41 percent of families had some type of pension coverage in 1998 through the family head or partner's current job (Federal Reserve Board 2001). Although there is no comparable information for North Carolina, it is likely that the rates are similar or possibly lower because of the prevalence of people in occupations that do not typically offer pensions (e.g., agriculture, forestry, fishing, sales, and service).

In the past, most workers with pensions were covered by defined-benefit (DB) plans. Today there is greater use of defined-contribution (DC) plans, which has several potential implications for both older adults in retirement and baby boomers. Unlike the DB plans, the DC plans are typically portable, but workers often must decide how much and when to contribute. Delaying participation can substantially reduce retirement benefits, and because retirees and workers must choose how to invest the funds, they bear the investment risk. Within the past five years, workers and retirees have clearly seen both the opportunities and the dangers inherent in DC plans.

An important issue that affects the retirement income of many older women involves their rights to benefit from their husband's pension in the event of divorce or his death. The federal Retirement Equity Act of 1984 requires that private pension plans have a joint and survivor's option. This means that a pension benefit will continue as long as either spouse survives. However, this protection of spousal claims on pension benefits applies only to private pensions. Because state pension plans are not subject to the federal law, state governments are not required to offer spousal consent to the waiver of a survivor pension. The majority of states, including North Carolina, do not have legislation or administrative policy governing spousal disclosure or consent regarding retirement benefits.

Public Assistance

While self-reliance is commendable and important to the public coffers, the timely use of public assistance is not only beneficial to individuals but also may prevent more costly public spending later to repair the harm caused by earlier neglect. For example, only about 26 percent of older adults eligible for federally funded food stamps are receiving this benefit, yet malnutrition remains a serious problem for many seniors that can lead to far greater health issues. Older adults and baby boomers must become knowledgeable about public and private resources available to assist them with their needs that have implications for their health and economic security. This is particularly true for public assistance programs, because older adults consistently underuse the programs for which they are qualified.

Priorities for Economic Security *in* North Carolina

1. In collaboration with the NC Institute on Aging and other partners, NCDOA will convene a special meeting to bring attention to the need for a comprehensive approach to the economic security issues facing older North Carolinians.
2. NCDHHS will consider the recommendations in the comprehensive study report on CAP/DA services by the NCIOM in an attempt to serve the maximum number of people within the budgeted appropriations for CAP services.
3. NCDHHS will ensure the maximum use of the NC Senior Care Program to assist eligible older adults with their prescription medication costs and otherwise promote access to prescription assistance.
4. NCDOA, SHIIP, and AARP will continue to lead an effort to educate the public about Medicare, Medicaid, and long-term care financing options.
5. NCDOA will continue its work with the NC Commission on Workforce Development and other partners to make job training and employment assistance programs more accessible to older workers with low incomes, having limited education, and/or residing in economically struggling regions and counties in the state.
6. NCDOA will partner with AAAs and other state and local stakeholders to explore ways to provide financial management education with special emphasis on vulnerable seniors.

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5 Senior-Friendly Communities

Celebrating North Carolina communities that chose to improve the quality of life of seniors and their families

Major Accomplishments (1999–2003)

- ✓ Advocates helped achieve significant expansion of prescription assistance for seniors.
- ✓ The future of senior centers was strengthened through implementation of the Senior Center Certification Process and the Ann Johnson Institute for Senior Center Management.
- ✓ The work of the Aging Information and Assistance (I&A) Task Force led to revised service standards and progress toward a statewide system.
- ✓ The General Assembly increased funding for public transportation, rural general public services, and the Elderly and Disabled Transportation Assistance Program (EDTAP).
- ✓ The General Assembly, in 2001, increased the Homestead Property Tax Exemption for low-income elderly and disabled persons.
- ✓ The North Carolina Division of Aging (NCDOA) and Area Agencies on Aging (AAAs) achieved national recognition for their implementation of the North Carolina Family Caregiver Support Program, with the support of many partners.
- ✓ NCDOA and NC Department of Public Instruction expanded the Senior Education Corps (SEC), linking senior volunteers with school children in 82 counties.
- ✓ The Senior Nutrition Program advanced the vision of "more than a meal" with new programs emphasizing health and nutrition.
- ✓ The NC Senior Consumer Fraud Task Force worked closely with the NC Coalition for Responsible Lending, the Attorney General's Office, AARP, as well as many other agencies and organizations to gain passage of the NC Predatory Lending Law in 1999.

Current and Future Concerns

- ✓ State funding for Senior Centers and AAAs has been reduced, which diminishes their capacity to help build senior-friendly communities.
- ✓ Development of a statewide system for I&A will require further funding.
- ✓ Substantial investment is needed to develop a viable transportation system for all citizens, especially seniors and disabled adults, throughout North Carolina.
- ✓ Many seniors with low incomes cannot afford adequate housing.
- ✓ Expansion and management of volunteer opportunities require adequate support.
- ✓ Building senior-friendly communities will require commitment, time, and resources.

While American society has a history of assisting older adults in important ways, including social security and public medical insurance, it has fallen short in other areas. For example, according to Howe's paper on building aging-sensitive communities (2001; p. 2), we have failed to make our communities adequately "aging sensitive, thereby enabling older people to maintain their independence and ensuring efficiencies in providing services to lessen the strain on [their] caregivers." Howe also notes that most American commu-

nities "have evolved in a manner that either requires people to move away when needs change or forces them to make less than desirable adaptations" (2001; p. 6).

The National Governors Association (NGA 2001) has acknowledged that a combination of public, private, and philanthropic investment in communities is essential in preparing for the transformation that aging baby boomers will bring as they begin to retire toward the end of this decade. The NGA has launched a new initiative specifically designed to help states create policies and programs to aid the nation's communities in meeting the challenge.

By focusing this concluding chapter of the *2003–2007 NC Aging Services Plan* on developing senior-friendly communities, the NC Division of Aging proposes that the future health, wealth, and social integration of seniors depends largely on what happens locally along with state and national developments. The NC Progress Board stated in its long-range plan, *NC 20/20* (2001), that an ultimate goal of the state is to make North Carolina a safe and vibrant place to live for all citizens, while respecting the unique character of its communities. This *State Aging Plan* embraces that goal and advances the following concept of *senior-friendly community* as one of its key components*:*

A senior-friendly community *offers a wide range of social and economic opportunities and support for all citizens, including seniors; values seniors' contributions to the community; promotes positive intergenerational relations; considers the needs and interests of seniors in physical and community planning; respects and supports seniors' desires and efforts to live independently; and, acknowledging the primary role that families, friends, and neighbors play in the lives of older adults, enhances their capacity for caring.*

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While nearly every community in North Carolina will see greater numbers of older adults in the future, many may not readily or easily see the effect of this aging nor respond proactively to tap the resources and meet the needs of their seniors. The proposed senior-friendly community is not only a desirable goal but a necessity for the interests of older adults, their families, and also for the communities themselves.

As the state agency responsible for administering programs under the Older Americans Act (OAA), the NCDOA is charged with helping "older people to secure equal opportunity to the full and free enjoyment" of the many objectives articulated under the OAA. While achievement of these objectives requires significant federal and state support, their realization ultimately requires the development of communities that:

- understand and accommodate the special needs of seniors, especially the most vulnerable.
- assure social and economic opportunities in employment, volunteering, and community service, without regard to age.
- facilitate independence through responsive transportation services and such physical considerations as easy-to-read street signs and well-lighted and accessible sidewalks.
- guarantee suitable and affordable housing.
- encourage meaningful activity with a wide range of civic, cultural, educational, spiritual, and recreational opportunities.
- provide access to well-coordinated supportive services.
- support people's independence and the free exercise of individual initiative in planning and managing their own lives.

Communities that respect and work toward achieving these objectives are *senior-friendly*. They enable senior households to remain an integral part of their community, however they chose to define it.

A senior-friendly community is not a term bound by any jurisdiction established for administrative purposes by government agencies. At the center of each senior-friendly community stands a neighborhood with older residents. The focus of senior-friendly community initiatives is individuals, neighborhoods, agencies, organizations, and programs—public and private—collaborating to remove barriers to services and opportunities and improve the quality of life of older adults wherever they live.

The NCDOA chose the Bladen County community of East Arcadia for the 2002 Ernest

B. Messer Award because it has excelled in addressing the needs of its older adults. While it is a small community with comparatively few material resources, it is nonetheless rich in vision, commitment, and action. With leadership from the East Arcadia Senior Citizens' Association and the support of the AAA, the faith community, and other partners, East Arcadia's 524 citizens (as of the 2000 Census) have proved that it is possible to make significant progress in making their community senior-friendly. Committed to achieving successful aging for its citizens, their accomplishments just since 2001 have included:

- developing a satellite adult learning center staffed by Bladen Community College. Recently, a 91-year-old resident of East Arcadia received his G.E.D.
- partnering with the faith community to have a volunteer-run telephone reassurance program and teams of volunteers helping with home repairs and improvements for older adults.
- receiving a grant from the Dr. Martin Luther King, Jr., Foundation to strengthen the bonds between the community's seniors and its youth.
- developing a congregate nutrition site as a central meeting place for its seniors that attracts more than 40 participants each day. With volunteers, the site has expanded to include activities for the mind and body.
- securing property—through local fundraising, a little state senior center funding, and assistance from rural development—to build a senior center.

To help replicate the success of East Arcadia statewide, the NCDOA will develop partnerships with the state's 17 Area Agencies on Aging, along with many other public and private interests, including North Carolina's strong network of local aging service providers. Because nearly every aspect of society will be affected by the aging of the population, the tasks of becoming senior-friendly are enormous. Advocacy and planning are essential activities for helping the state and communities become aware of the changes inherent in an aging society. These are two of ten activity areas discussed in this chapter that the NCDOA considers key to building senior-friendly communities in ways that are consistent with the mission of the NCDOA and AAAs under the OAA and state statute. The other eight areas are senior centers, information and assistance (I&A), family caregiver support, volunteer coordination, nutrition, housing, transportation, and consumer protection. Progress in all ten of these areas should strengthen the preparedness of North Carolina communities to enhance the quality of life of today's older North Carolinians and their families, as well as improving the outlook for future cohorts of older adults.

Advocacy

For North Carolina and its communities to be senior-friendly, there must be entities that can focus attention on the needs and interests of seniors, individually and as a group. The OAA authorizes state agencies on aging to serve as effective and visible advocates for older adults. The NCDOA has embraced this charge and is involved in numerous advocacy efforts on behalf of older adults in North Carolina, ranging from those that pertain to a single older person to those that affect large numbers of seniors. In its advocacy, the NCDOA works with a wide range of public and private partners. Success in this area is illustrated by the NCDOA's role in advocating for prescription drug assistance for seniors, a top priority issue of senior advocacy groups for the last five years. In December 2001, the Health and Wellness Trust Fund Commission voted to allocate $90 million over the course of three years from tobacco settlement funds to establish a limited prescription drug assistance program for adults 65 years of age and older.

North Carolina is fortunate to have numerous advisory and advocacy groups concerned with seniors. Two of these groups, the Senior Tar Heel Legislature (STHL) and the Governor's Advisory Council on Aging, are authorized by state legislation, with staff support provided by the NCDOA. The current priorities of these two groups, along with those of the North Carolina Study Commission on Aging and the North Carolina Coalition on Aging, are reviewed in Appendix A of this *Plan*.

Another important component of advocacy is the State Long-term Care Ombudsman pro-

gram, administered by the NCDOA. It is designed to advocate for older adults individually and, at the same time, address overall systemic issues. The ombudsman program works on behalf of residents in nursing and adult care homes and operates through a network of statewide ombudsmen, regional ombudsmen located in the AAAs, and over 1,300 "grassroots ombudsmen" who serve on local community advisory committees. In FFY 2001, the ombudsman program processed over 3,600 complaints from residents of long-term care facilities and their families, with 84 percent of these complaints fully or partially resolved. The NCDOA also administers the legal assistance program, required by the OAA, which gives particular emphasis to those who are vulnerable due to economic concerns or frail health, and who lack knowledge about their rights or are unfamiliar with the available avenues to redress grievances.

Other state agencies also have important roles in promoting the interests and rights of seniors. Most especially, this includes the NC Division of Social Services (NCDSS), in administering the Adult Protective Services (APS) and Guardianship programs, and the Seniors' Health Insurance Information Program (SHIIP) in the Department of Insurance. APS and guardianship are services that the NC Institute of Medicine Task Force on Long-Term Care described as essential to individuals who have functional, medical, or cognitive impairments (see the chapter on long-term care and aging for a discussion of these services).

Senior Centers

All people need places that offer them identity, opportunities, and assistance. For some, these are places of employment, education, or worship. Others find what they need in their civic or fraternal affiliations. For many older adults, senior centers help serve this function. Senior centers also serve a vital role in the community by providing a focal point for services to promote independence and wellness for older adults. While senior centers are primarily locally financed, the NCDOA provides three funding sources designed to support and improve their operations: Senior Center Operations, Senior Center General Purpose funding, and Senior Center Outreach. Senior Center Operations is one of 18 services that counties may choose to fund through the Home and Community Care Block Grant (HCCBG). The General Assembly also provides appropriations for Senior Center General Purpose funding and Senior Center Outreach. The funding for General Purpose support and Outreach has been reduced by nearly 30 percent in SFY 2002–2003 from the previous year. The combined federal and state allocation for these programs is a little under $2.8 million for SFY 2002–2003.

The *1999–2003 Aging Services Plan* identified strengthening the capacity and role of senior centers as a major goal. The NCDOA has moved to achieve this goal by successfully implementing the Senior Center Certification Process and the Ann Johnson Institute for Senior Center Management.

The Senior Center Certification Process recognizes senior centers that meet specific criteria established for two models—Centers of Excellence and Centers of Merit. As of January 2003, there were 20 Centers of Excellence and 10 Centers of Merit among the 158 existing and developing senior centers that receive state funding. The state's budgetary difficulties have limited the ability of the NCDOA to offer a financial incentive to certified centers, which is an important aspect of the certification program.

The Ann Johnson Institute provides leadership and career development training for senior center personnel. The NCDOA has developed and offered three of the six training modules of this curriculum since November 2001.

Beginning in 2003, the NCDOA plans to begin an important third step in strengthening senior centers. Given the aging of the population, especially driven by baby boomers, the NCDOA will convene a work group to develop a model of the Center of the Future. A 2001 survey of senior centers in North Carolina (Salmon 2002), conducted for the NCDOA, revealed some of the challenges that centers and communities face in preparing to meet the needs and interests of baby boomers. These include growing numbers of participants and increasing expectations for centers whose facilities, staffing, and funding are inadequate.

Information and Assistance

A major frustration for many people is not knowing whom to call when there is a question or problem. Their frustration is made worse when they are referred from one organization to another and still are not helped. For seniors, such experiences create a very unfriendly community, sometimes with consequences that are personally devastating.

Shortly after the *1999–2003 Aging Services Plan* was presented, the Governor's Advisory Council on Aging acted on the plan's goal of helping older adults make informed choices, whether they are planning for retirement, facing the changes of later life, or seeking immediate help. The advisory council held a special symposium and recommended that the NCDOA initiate a process to develop a comprehensive, professional, and uniform information resource system that could empower all citizens of North Carolina with up-to-date, reliable, and easily accessible information and assistance (I&A). The NCDOA responded to the Council's charge to lead in the development of I&A, with the support of a special I&A Task Force.

The *NC Long-Term Care Plan* endorsed the importance of I&A as one of the core services that should be available to all older and disabled adults and their families throughout the state (NCIOM 2001). In 2002, the NCDHHS committed $100,000 from the Mental Health Trust Fund to conduct a study to evaluate the feasibility of global access to community resource information across North Carolina, as an important support for individuals and families seeking services.

By June 2003, the NCDHHS expects to have a clear strategy for building an effective statewide I&A system that should expand existing local and regional information and referral databases, be linked to the CARE-LINE and 2-1-1 services, and be accessible throughout the state via the Internet. The NCDOA will continue to work collaboratively with all I&A providers in the state (e.g., the NC United Way and its 2-1-1 Call Centers and the DHHS Office of Citizen Services and its CARE-LINE service) to improve older adults' access to information and services.

Family Caregiver Support

Senior-friendly communities are also family-friendly because they sustain the efforts of families to care for their members, particularly those with disabilities. The support of family caregivers is crucial to maintaining quality long-term care in North Carolina, as discussed in the chapter on long-term care and aging.

In establishing the Family Caregiver Support Program (FCSP) in 2001, the NCDOA envisioned a future when families would enter caregiving with the knowledge and assurance that they could call upon the business, faith, and health and human service communities to assist with information, counseling, problem solving, respite, and formal services when needed. Toward this end, the NCDOA asked each of the state's AAAs to create a position of Family Caregiver Resource Specialist. The primary responsibility of the Family Caregiver Specialists is to lead numerous activities designed to increase caregiver support in the following five areas: (1) information about available services; (2) assistance in gaining access to these services; (3) counseling, organization of support groups, and caregiver training; (4) respite care; and (5) supplemental services, on a limited basis, to complement the care provided by caregivers.

Input from family caregivers, obtained in a variety of ways, is considered a cornerstone of FCSP development, as is a focus on developing partnerships that can extend the limited funds allocated to this program (a little under $2.8 million in federal funds for SFY 2002–2003). These collaborative efforts have helped to build a nationally recognized program. Partners include the Duke Family Support Program, AARP, the NC Cooperative Extension Service, the Center for Aging Research and Educational Services (CARES) at UNC-Chapel Hill, the Carolinas Center for Hospice and End-of-Life Care, and the NC Alzheimer's Association Chapters. Recently, the NCDOA established a Steering Team for the FCSP, with leaders from education, business, health and human services, and the faith community to help direct the program's future development and generally bring about positive changes in support of caregivers.

Volunteer Coordination

Community spirit is best seen through the efforts of volunteers who respond to help friends, neighbors, and fellow citizens. No group embodies the volunteer spirit better than older adults. According to a statewide survey conducted in 2000 (Guseh and Winders 2001), almost 60 percent of adults age 60 and older volunteer. While not normally seen as a form of volunteerism, grandparents raising grandchildren is yet another example of how seniors are contributing to their families and communities. The 2000 Census reports that almost 80,000 grandparents are their grandchildren's principal caregivers in North Carolina. These numbers show that older North Carolinians are highly productive in providing valuable services in their communities.

The NCDOA sees volunteerism as vital to senior-friendly communities. Every community depends on volunteers for such critical services as home-delivered meals and home repairs. In fact, the NCDOA recognizes the importance of volunteerism in every program it administers (e.g., the state ombudsman program, family caregiver support program, and senior center operations). The value of volunteerism, though, extends well beyond seniors serving other seniors.

The NCDOA, in collaboration with the NC Department of Public Instruction, is working to develop the Senior Education Corps (SEC) statewide. The SEC is an intergenerational program linking the experience, talent, and cultural awareness of seniors with the enthusiasm, curiosity, and desire to learn of school children. In 2000, with a $35,000 grant from the Z. Smith Reynolds Foundation, the NCDOA convened a statewide conference, "Connect for Success," in Winston-Salem, gathering representatives from the school systems and aging organizations, as well as senior volunteers. The NCDOA also awarded mini-grants to counties to help establish and expand their SEC programs. Currently, 82 counties have active SEC programs. Additionally, the NCDOA sponsors two Foster Grandparent Programs, which provide small stipends to seniors, meeting the low-income criteria, to serve as foster grandparents or extended family members to children and youth in hospitals, schools, correctional institutions, and day care centers.

Nutrition, Housing, and Transportation

Food, shelter, and transportation are clearly essential to everyone in a community. Senior-friendly communities are concerned that many older adults are still at risk of malnutrition, live in inadequate housing, and lack the ability to travel freely and safely.

Nutrition

The NCDOA administers the Senior Nutrition Program to provide meals to older adults in group settings and individual homes. The former is commonly called "congregate nutrition services," which are offered at such places as senior or community centers, churches, or schools. The service of delivering meals to individual homes is known as "home-delivered meals" or "meals on wheels." The primary focus of the Senior Nutrition Program remains to serve hot, nutritious meals to older adults; this is especially important because 41 percent of congregate participants and 89 percent of those receiving home-delivered meals are at moderate to high risk of malnutrition (NCDOA 2002). Additionally, the OAA envisioned these programs being "more than a meal" and encourages the provision of related services including nutrition screening, education, and counseling. These services help older adults identify their nutritional needs to remain healthy and to manage nutrition-related chronic conditions such as heart disease, hypertension, and diabetes.

The congregate meal program offers older adults opportunities for social interaction, mental stimulation, and informal support. The home-delivered meal program allows volunteers who deliver meals an important opportunity to check on the status of homebound older adults and to help the nutrition provider to alert appropriate agencies if additional assistance is needed. The programs also offer active older adults the opportunity for valuable community service. Many home-delivered meal volunteers are themselves older adults. These volunteers perform not only the necessary and time-consuming task of delivering meals individually, but they also enjoy and provide the opportunity for social interaction and companionship.

Helping older adults learn to shop for and prepare meals that are economical and address any special dietary needs is another important goal of the Senior Nutrition Program. To this end, the program helps older adults connect with such other health or supportive services as transportation, in-home and home-health aide services, home modification, and food assistance programs such as food stamps. In 2000, the NC Cooperative Extension Service partnered with the NCDOA to provide the nutrition education program called "Partners in Wellness." The NCDOA also collaborated with the Division of Public Health and the NC Department of Agriculture to implement the Senior Farmers Market Nutrition Program that allows seniors to use food stamps to purchase fresh produce at the local farmers market. Most recently, the NCDOA worked with the Division of Social Services to secure a federal grant from the US Department of Agriculture to test different outreach methods to improve food stamp participation among older adults. Currently, only about 26 percent of eligible older adults in North Carolina take advantage of this 100 percent federally funded benefit (NCDSS 2002).

Housing

In North Carolina, 31 percent of all homeowners are age 60 and older, yet among older homeowners, over 76,000 reported incomes for 1999 that were below poverty (US Census Bureau 2002, SF3, HCT24). This figure represented 47 percent of the homeowners of all ages with income below poverty and exceeded the national average of 42 percent. Among renters age 65 and older who provided information, 53 percent, or almost 48,000, spent more than 30 percent of their household income on rent. Furthermore, based on 2000 Census information, almost 5,000 North Carolina homeowners and renters age 65 and older lack complete plumbing facilities in their homes.

More disturbing news is found in the statistics of emergency shelters—where the largest increase among the homeless between 2001 and 2002 in North Carolina were among those 55 and older. While the total population of homeless reported by shelters increased by 5 percent during this period, the older homeless grew by 71 percent (totaling 3,494 persons in 2002), according to the NC Office of Economic Opportunity (2002). These statistics profile the difficulties many older North Carolinians face in securing good and affordable housing for themselves and their families. For this reason, the NCDOA works closely with aging advocacy groups, the NC Housing Finance Agency, and others to promote safe, affordable, and accessible housing as a priority of older North Carolinians with low incomes.

Since 1999, the Governor's Advisory Council on Aging and the STHL have emphasized three housing issues: (1) increasing property tax relief for older and disabled adults with low incomes, (2) passing legislation to require the licensure of mortgage brokers, and (3) expanding the availability of affordable rental property for older adults with low incomes. They achieved some success in their advocacy. In its 2001 Session, the General Assembly increased the Homestead Property Tax Exemption for older and disabled persons with low income. The 2001 General Assembly also addressed the second concern by requiring mortgage bankers and brokers to be licensed by the state (S.L. 2001-393 [S904]).

Less progress has been made in helping to provide affordable housing. In 2002, the NCDHHS established a Housing Workgroup to address the affordability of housing for individuals with low incomes. The NCDOA and others in the workgroup review NC Housing Finance Agency (NCHFA) tax credit applications to determine if they meet the specific needs of the intended clients. As of 2002, 101 affordable rental apartment units have been approved under the tax-credit program administered by the NCHFA. Still, the state's experience with hurricanes aggravated an already serious situation, only made worse with a reduction in funds available through the Housing Trust Fund, which was cut from $8 million in 2000 to $3 million in 2001 and $2.7 million in 2002. While North Carolina also has Urban Development's Section 8 housing vouchers, aging advocates are concerned that these funding sources are nevertheless inadequate for the housing needs of many older adults. The Governor's Advisory Council on Aging intends to hold a special forum on the housing needs of seniors in 2003.

Transportation

More than 80 percent of adults in North Carolina age 65 and older have active drivers' licenses. They provide their own transportation and often drive many volunteer miles for family members and friends who need rides to stores and medical appointments. The issue of driver safety will become increasingly important: There will be more older drivers on the road in the near future as baby boomers age. Encouraging drivers to update their skills in courses such as AARP's Driver Safety Program will help keep older drivers safely on the road longer. The state also must be interested in designing roadways and pedestrian areas with older adults in mind. However, many older adults eventually require an alternative to driving.

There are some transportation services available in every North Carolina county. In most, the public transportation system serves both the general public and the clients of human service agencies. In a few counties without public transportation, there are human service transportation systems that provide services to clients of these agencies.

Because transportation services are funded and administered both by the NC Department of Transportation (NCDOT) as well as human services agencies, coordination is very important. To facilitate this coordination, the NC Human Service Transportation Council advises NCDOT, NCDHHS, and other state agencies concerning human services transportation policy. In 2002 NCDOT also funded a Human Services Transportation Program Administrator position located in the NCDHHS. NCDOT and NCDHHS have established an interagency Transportation Report Information Project (TRIP) team to review current policies and procedures and identify where improvements can be made in delivering and reporting on transportation services. The NCDOA has a designated representative on the NC Human Service Transportation Council and the interagency TRIP team.

Funding increases for public transportation, rural general public services, and transportation assistance for seniors and people with disabilities have been major accomplishments during a period when state budget constraints in other areas have reduced services. Annual state funding for public transportation has more than doubled, from $34 million in 1999 to almost $84.5 million in 2002. The 2002 allocation included $5.5 million to the Elderly and Disabled Transportation Assistance Program (EDTAP), which was specifically designed for transportation services to older adults and younger adults with disabilities. Additionally, the NCDHHS has estimated that its agencies expended more than $43.5 million in 2001 for transportation services through such programs as Medicaid, Work First, the HCCBG, services for the blind, vocational rehabilitation, and other programs.

The Governor's Advisory Council on Aging identified expanding transportation services as one of the major issues at its 2000 Symposium on Serving Older Adults in Rural Areas (Bearon 2000), and the council plans to hold a special forum on transportation in the near future.

Consumer Protection

While we would like to think that all sectors of society would support the concept of senior-friendly communities, there are some individuals who see older adults as easy prey for their ruthless schemes. Consumer fraud that targets seniors is a growing problem, not just in North Carolina, but nationwide.

The fast growth of businesses that use telemarketing has accelerated the proliferation of telemarketing operations. According to the NC Attorney General's (AG's) Office, today, it is estimated that over 140,000 telemarketing firms are in operation in the US, with 10 percent of them believed to operate as illegal "boiler rooms," stealing an estimated $10 to $40 billion nationwide each year from consumers. The NC AG's Office estimates that consumers lose $200 to $300 million each year to these fraudulent telemarketers. Losses of $50,000 to $100,000 for a single victim are not uncommon.

While these fraudulent telemarketers prey on people of all ages, seniors are their favorite targets. In just one week in 2002, the Telemarketing Fraud Prevention Project in the NC AG's Office detected eight different telemarketing fraud "hits" on seniors, with total losses amounting to $145,000. Other types of frauds (e.g., identity theft; home repair frauds; and deceptive sales, contests, or sweepstakes)

are also rampant. For example, unscrupulous contractors offer "super bargains" on home improvements or repairs, but having taken the consumer's money, leave the job unfinished or improperly done. Some companies use high-pressure sales tactics to sell older consumers expensive products that are of little or no benefit.

In response to the rapid growth of consumer fraud that targets seniors in North Carolina, the NCDOA joined forces with AARP and the NC AG's Office to establish the NC Senior Consumer Fraud Task Force in 1998. The task force brings together federal, state and local law enforcement agencies, aging advocates, the aging network, state and local Better Business Bureaus, and crime prevention agencies. One of the task force's primary missions is to educate consumers about fraud and scams operating in North Carolina and teach them how to avoid becoming victims. The NC AG's Office regularly disseminates "Consumer Fraud Alerts," designed to inform consumers about the latest scams and other deceptive practices operating in the state. These alerts are posted on the NCDOA website.

The Senior Consumer Fraud Task Force worked closely with other key stakeholders to get the NC Predatory Lending Law of 1999 passed. This law is considered one of the strongest predatory lending laws in the country. Aging advocates continue to promote other consumer protections, including passage of the "Do Not Call" legislation.

Planning and Evaluation

While this chapter began with advocacy, because it is the first building block for developing senior-friendly communities, it concludes with planning and evaluation, a vehicle to realize the advocated changes and improvements in North Carolina. Planning and evaluation activities use increased awareness to help construct and sustain communities that are senior-friendly.

The NCDOA plays a leadership role in conducting planning and evaluation activities that lead to creating senior-friendly communities in North Carolina. Specifically, the NCDOA's planning and evaluation activities are guided by three distinct yet interrelated tasks: increasing the focus on results, expanding local capacities, and improving collaboration across agencies and programs.

The focus on results is indirectly but clearly driven by the federal Government Performance and Results Act (GPRA) of 1993. The GPRA compels federal agencies and programs to set performance-oriented goals and establish a mechanism to measure the degree to which these goals are met (US General Accounting Office 1997). Since 2000, the NCDOA has participated in the national, GPRA-prompted Performance Outcome Measures Project (POMP), designed to develop measures suitable for assessing the performance of community-based aging services. The AAAs in Regions I and N; Johnston County Council on Aging; Senior Services, Inc., of Forsyth County; and the CARES program at the UNC-Chapel Hill School of Social Work are the NCDOA's partners in this project.

The NCDOA is interested in expanding local capacities to encourage community ownership and full participation in planning and evaluation activities for creating senior-friendly communities throughout North Carolina. In 2002, the NCDOA, with support from the NCDHHS Long-term Care Cabinet, developed an approach to support local planning for long-term care (see the chapter on long-term care and aging for further discussion of this). The NCDOA has also emphasized community planning in its development of the North Carolina Family Caregiver Support Program. The NCDOA is interested in pursuing other means of supporting communities as they assess the extent to which they are senior-friendly and pursue strategies to respond to the aging of their populations. North Carolina can learn from the experience of AARP in its development and use of *Livable Communities*, an evaluation guide that helps communities to create an environment that supports independent living as people get older (Pollack 1999). The NCDOA anticipates assisting North Carolina in joining the National Governors Association (NGA) and other states in examining policies and practices that can help communities adapt to meet the needs of older citizens.

In supporting communities becoming senior-friendly, collaboration among agencies and programs, public and private, is imperative. In the past several years, the NCDHHS and its divisions

have implemented several initiatives to strengthen the collaborative approach to planning and evaluation. A prime example is the establishment of the Long-term Care Cabinet, a body composed of the division directors to coordinate all long-term-care–related work across the department. A product of collaboration is the 2001 report of the North Carolina Task Force on Aging and Developmental Disabilities that provides a blueprint for improving the quality of life for older persons with developmental disabilities. Other examples of collaboration cited in this chapter include the NC Human Service Transportation Council, the NCDHHS Housing Workgroup, and the Family Caregiver Steering Team. All of these efforts of interagency and cross-program collaboration are essential to helping North Carolina energetically and deliberately prepare for the challenges and opportunities we will face as our population ages.

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The themes that have guided this *Aging Plan*, as discussed in Chapter 1, can also serve the communities as they seek to become more senior-friendly. These communities will draw on the talents and resources of active seniors while enhancing services for those who are vulnerable because of their health, economic hardships, social isolation, or other conditions. They will be judged by how well they value diversity and address disparities among their increasingly diverse older population. They will assure stewardship of formal and informal resources as they respond to the needs of today's seniors while helping aging baby boomers and younger generations prepare for the future.

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Priorities for Senior-Friendly Communities *in* North Carolina

The NC Division of Aging, working with the state's 17 Area Agencies on Aging along with many other public and private interests, including North Carolina's strong network of local aging service providers, and aging advocates will:

1. Convene a task force to develop a blueprint for designing senior-friendly communities.
2 Enhance the voluntary process of certifying senior centers as "Centers of Excellence" and "Centers of Merits" and begin developing a model of the Center of the Future that will be responsive to the needs and interests of baby boomers.
3. Help address community needs, including services for vulnerable seniors and children, through the promotion of volunteer opportunities that enable older adults to use their skills, experience, and knowledge.
4. Promote a statewide, comprehensive, professionally administered, and computerized system for Information and Assistance (I&A) that assists seniors and their caregivers in locating and accessing needed services.
5. Educate seniors and their families about consumer fraud and other deceptive practices that particularly target this segment of the population.

In addition,

6. The Governor's Advisory Council on Aging will hold special forums on transportation and housing to develop recommendations for the Governor and the DHHS Secretary to strengthen these community supports.

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Appendices

Appendix A

Views of Advocates

Representing the concerns of older adults, their families, and communities

North Carolina is fortunate to have a number of groups whose members actively study and represent the views of older adults to state and local government. Three of these groups—the NC Senior Tar Heel Legislature (STHL), the Governor's Advisory Council on Aging (Council), and the NC Study Commission on Aging (Commission)—have authority under state law to present their recommendations for improving the well-being of seniors. Additionally, the NC Coalition on Aging (Coalition) is also highly influential as the focal point of many and varied organizations working together to set a legislative agenda to improve the quality of life for older adults.

The STHL was created by the General Assembly in 1993 with the passage of S.B. 479. With one delegate (plus in some cases an alternate delegate) from each of North Carolina's 100 counties, the STHL assesses the needs of older citizens and establishes annually three to five priorities for consideration by the General Assembly. The Governor's Advisory Council is charged in NCGS 143B-180 with making recommendations to the Governor and the DHHS Secretary to improve services to older adults. The Study Commission on Aging, created by the State Study Commissions and Committees Act of 1987 (Chapter 873, Section 13.1), is responsible for studying the issues of availability and accessibility of health, mental health, social, and other services needed by older adults. The NC Coalition of Aging's 38 organizations, which include AARP-NC and many trade and consumer organizations, are committed to addressing the needs and promoting the dignity, self-determination, well-being, and contribution of seniors—both as individuals and within the context of their families and communities.

The table shows priorities that at least two of the organizations have identified as recommendations for the 2003–2004 State Fiscal Year. The STHL set 5 priorities, the Council and the Coalition each identified 10, and the Commission recommended 16.

All four groups voiced support for maintaining the Community Alternatives Program for Disabled Adults (CAP/DA) as a means of enabling persons to remain in their homes as long as possible. While supporting CAP/DA, the Commission also encouraged further examination of the program to assure its effectiveness. All four groups expressed concern that there are still barriers to implementing national criminal background checks for employees of long-term care facilities. Three of the four groups encouraged continued support of the Home and Community Care Block Grant (HCCBG), especially for impaired older adults, and they recommended making permanent the state income tax credit for long-term care insurance premiums.

Table A1. Top Legislative Priorities of Advocacy Groups

Priority	STHL	Council	Commission	Coalition
Maintain CAP/DA as a viable service	✓	✓	✓	✓
Assure implementation of national criminal background checks for employees of long-term care facilities	✓	✓	✓	✓
Maintain support of the Home and Community Care Block Grant	✓	✓	✓	
Continue improving access to prescription drugs for older adults with low and moderate incomes		✓	✓	✓
Make permanent the state income tax credit for long-term care insurance premiums		✓	✓	✓
Strengthen dental care services for residents of long-term care facilities	✓	✓		
Support the development and operation of senior centers	✓	✓		
Increase state revenues to provide services for older adults		✓		✓
Strengthen the direct care workforce; support of increased nurse aide salaries and benefits			✓	✓
Expand the Special Assistance In-Home Demonstration			✓	✓

Groups

The NC Senior Tar Heel Legislature (STHL)
The Governor's Advisory Council on Aging (Council)
The NC Study Commission on Aging (Commission)
The NC Coalition on Aging (Coalition)

Appendix B

State Agencies

Major Activities and Future Directions

Serving older adults, their families, and communities

Various divisions and offices within the Department of Health and Human Services have identified their major activities and future directions for the next four years in support of older adults and their family caregivers. Several agencies from other departments have also identified significant initiatives involving older North Carolinians. Collectively, these activities and initiatives serve to promote the goals of the *State Aging Services Plan* to improve the health, socioeconomic status, and social integration of seniors within their communities. They are also consistent with the plan's major themes of drawing on the talents and resources of active seniors, enhancing services for vulnerable older adults, valuing diversity while addressing disparity, being responsible stewards by maximizing formal and informal resources, and assisting baby boomers and younger generations to prepare well for their future.

Divisions and Offices of the Department of Health and Human Services

Aging, Division of

In maximizing resources to offer home and community-based services and support for seniors and their caregivers, the Division will work with Area Agencies on Aging and local providers to:

- assure appropriate use of funding sources in delivery for services, enhancing consumer contributions, and promoting reasonable unit rates for services by strengthening policies and practices for screening and referring clients.
- assure adequate monitoring of the administration and delivery of services, in keeping with the DHHS's renewed emphasis on accountability of public resources.
- support and participate in the Performance Outcome Measures Project, funded by the US Administration on Aging, and participate in the DHHS initiative to establish performance-based contracts.

In strengthening local capacity for responding to an aging society, the Division will:

- take the lead in organizing and implementing "A Communications and Planning Network to Support Families in Their Long-Term Care Roles," which is based on recommendation no. 16 of NCIOM's *2001 Long-Term Care Plan for North Carolina*. The Division will work with at least two or three volunteer counties or multicounty regions to support local planning for the long-term care of older and disabled adults.
- enhance the voluntary process of certifying Senior Centers as "Centers of Excellence" and "Centers of Merit" and begin developing a model of the "Center of the Future" that will be responsive to the needs and interests of baby boomers.
- increase the statewide availability of medication management services by coordinating Title III-D funds with the Senior Care medication management program, administered by the Office of Research, Demonstrations, and Rural Health Development.

- address health disparities that exist among various groups of seniors through collaboration with the Division of Public Health and its Office of Minority Health and Health Disparities, and others.
- educate members of the media about aging and senior issues in collaboration with DHHS Public Affairs.
- help address community needs, including services for vulnerable seniors, through the promotion of volunteer opportunities that enable older adults to use their skills, experience, and knowledge.

In supporting individuals and families in their efforts to manage their current affairs and prepare for the future, the Division will:

- promote a statewide comprehensive, professionally administered, and computerized I&A system that assists seniors and their caregivers in locating and accessing needed services by building upon the Information and Assistance (I&A) Feasibility Study, conducted in early 2003.
- promote healthy aging program development and collaboration by working closely with the Division of Public Health, the Institute on Aging, and other stakeholders.
- support consumer-directed care for seniors and their family caregivers by assisting the Office of Long Term Care in developing appropriate service delivery models.
- expand efforts as a visible elder rights advocate and launch a Family Empowerment Initiative for families of residents of adult care homes and nursing homes and a multidisciplinary Law Enforcement Initiative for vulnerable seniors.
- promote the need for expanding financial planning and educational services for seniors and baby boomers with a focus on long-term care planning, in partnership with the NC Institute on Aging, SHIIP, AARP, and others.
- develop effective strategies that enhance employment opportunities for older workers, in collaboration with other key stakeholders in the public and private sectors.
- educate seniors and their families about consumer fraud and other deceptive practices that particularly target this segment of the population.
- develop a multifaceted system of supports for caregivers of persons with Alzheimer's and other chronic and disabling conditions through the Family Caregiver Support Program and Project C.A.R.E.
- support the recommendations of *Aging and Developmental Disabilities: A Blueprint for Change*, a report from the NC Task Force on Aging and Developmental Disabilities, to enhance cooperation between the aging and developmental disabilities services networks to meet the needs of the growing population of older adults with developmental disabilities.

Developmental Disabilities, NC Council on

- To ensure that choice and quality of life characterize later life for older adults with developmental disabilities, the Council proposes to release funds competitively for projects that address the following areas of emphasis: medical (health care concerns related to aging); functional (maintaining of independence in activities of daily living); living arrangements and primary support system; social and leisure (general life-style choices); and legal and financial (retirement income planning, guardianship, advance health care directives).

Economic Opportunity, Office of

In promoting services to older adults with low incomes, the Office will:

- promote outreach activities targeting seniors for community-based food and nutrition services.
- promote the inclusion of the older population in programs and services sponsored by local community action agencies and homeless assistance providers.

- maintain seniors as a priority population to receive services through the NC Weatherization Assistance and Heating Air Repair and Replacement Programs.

Facility Services, Division of

In overseeing nursing homes and adult care homes, the Division will:

- assure access to nursing and adult care homes by maintaining the supply of beds through the Certificate of Need program.
- assure regulatory compliance in licensed nursing homes and adult care homes through the programs involving monitoring, complaint investigation, and penalties for noncompliance.
- address the health and safety of residents in long-term care facilities by encouraging state funding for additional staff positions designed to increase regulatory oversight for long-term care facilities.
- address the safety of older residents in adult care homes that also house younger residents with mental illness by conducting a study exploring the merits of regulations and necessary new legislation.

In promoting quality of care, the Division will:

- provide technical assistance to nursing homes and adult care homes, including information on best practices and problem-solving consultation.
- collaborate in examining the problem of aide recruitment and retention, identifying innovative and successful strategies for facilities and home care settings and recommending any policy and program changes that could strengthen the supply of paraprofessionals.
- encourage paraprofessional aides to enroll in specialized training courses through collaboration with the NC Department of Community Colleges.
- provide education, support, and encouragement for nursing homes and adult care homes implementing the Eden Alternative and collect data to evaluate the effect of Edenization on infections, pressure sores, incontinence, mobility, medication use, discharges, staff turnover and absenteeism, and other variables.

Long Term Care, Office of

Leading the effort to realize a coordinated system of long term care in North Carolina, the Office will:

- coordinate interdivisional activities in such areas as housing, human services transportation, consumer-directed care, and direct care workforce development.
- use the Real Choice grant to (1) review state and federal policies governing home and community-based services to identify policies that contribute to an institutional care bias, (2) develop a career ladder to support initial and professional development opportunities for direct care staff in home and community settings, (3) use public education and awareness efforts to promote recruitment and retention of direct care workers, (4) collect and analyze data relevant to workforce issues, and (5) develop a quality improvement system for direct care workers.
- lead in developing models to support consumer-directed care for seniors and their family caregivers.

Medical Assistance, Division of

In seeking ways to expand services, within the context of a difficult budget environment, the Division will:

- identify ways to reach the maximum number of people within the budgeted appropriation, based on the findings and recommendations of the NC Institute of Medicine's study of CAP/DA services.
- explore possible waiver options that would allow expansion within existing funds.

- strive to continue providing a comprehensive array of preventive and treatment health services (e.g., annual health screenings, prescription drugs, physician services, hospital care, dental care, vision care, personal care services, etc.) to eligible Medicaid enrollees.

In facilitating greater independence for people with disabilities, the Division will:

- design and implement, through the Nursing Facility Transition grant from the federal Centers for Medicare and Medicaid Services, a program to transition nursing facility residents with disabilities who wish to live outside an institutional setting.

Mental Health, Developmental Disabilities, and Substance Abuse Services, Division of

In seeking ways to expand services, within the context of a difficult budget environment, the Division will:

- begin to implement the recommendations of "Aging and Developmental Disabilities: A Blueprint for Change," a report from a Council on Developmental Disabilities–sponsored task force to investigate integration of aging services and developmental disabilities services.
- establish a statewide advisory committee to monitor implementation of the report.
- develop a Memorandum of Agreement among agencies working with the aging population and with people who have developmental disabilities.

In assuring adequate residential treatment, the Division will:

- provide specialty services for people who are currently being served in state hospitals' certified nursing units by creating at least two 20-bed Enhanced Behavioral Care units in community-based nursing facilities.
- support the development and operation of Special Care Units for Mental Health Disabilities, as specified in 10 NCAC 42D Section .2000, in collaboration with the Divisions of Social Services and Facility Services.

In supporting local services, the Division will:

- expand outreach effort for older adults at the local level, in support of the goal of the Mental Health Planning Council.
- establish Geriatric Mental Health Teams at Local Management Entities to provide communities with specialized services, technical assistance, and consultation related to the needs of the older adult population.
- expand training opportunities for staff who provide services for seniors with mental health, developmental disabilities, or substance abuse service needs.

Public Health, Division of

In promoting the health and quality of life of North Carolina's older adults by reducing death, disease, and disability, the Division will:

- provide leadership in the statewide effort for building capacities at the community level.
- serve as a program resource on health promotion for older adults.
- provide information and resources to health and aging service providers.
- provide technical assistance and training, including conferences and workshops on health promotion and aging.
- enhance the delivery of effective health promotion/disease prevention programs through partnership building among state and local public and private organizations and collaboration on healthy aging initiatives.
- increase public knowledge about the importance of healthy aging through a public awareness campaign.

- update the Health Profile of Older North Carolinians publication in collaboration with the State Center for Health Statistics and Division of Aging.

Research, Demonstrations, and Rural Health Development, Office of

In helping seniors cope with the rising costs of prescription drugs and managing their medication regimen, the Office will:

- administer the North Carolina Senior Care prescription drug program.
- explore ways to expand the NC Senior Care program. For example, a Medicaid waiver application was submitted in early 2003 to cover all diseases. Funding from the Health and Wellness Trust Fund Commission (HWTFC) would be used as the state match required to access federal funds upon approval of this waiver request.
- promote, support, and provide technical assistance to medication management activities for seniors, including development and implementation of the prescription assistance centers funded by the HWTFC.
- facilitate access to free public and private drug programs for seniors through Medication Access and Review Program software supplied to the 30 health service providers serving North Carolinians with low incomes and the 24 medication management centers throughout the state.

Services for the Blind, Division of

In assisting blind, visually impaired, and deaf-blind seniors to maximize their leadership, empowerment, independence, productivity, and integration and full inclusion into the mainstream of society, the Division will:

- continue to promote the prevention of blindness through education, vision screenings, and eye-related medical treatment.
- continue to provide an array of comprehensive services including adjustment to blindness services, low vision services, assistive aids and technology, home modifications, peer support groups, health support services, family adjustment services, safe travel skills, in-home aide services, and employment services.
- seek program innovation, expansion, and increased funding to help keep up with the needs of this growing population.
- expand outreach efforts to better address the needs of the unserved and underserved segments of this population.
- conduct activities to help improve the public's understanding of the needs and abilities of blind, visually impaired, and deaf-blind individuals.
- collaborate with local, community partners to best utilize available resources.
- provide awareness and sensitivity training programs and support for other agencies, organizations, and businesses that provide services for and work with individuals who are blind, visually impaired, and deaf-blind.

Services for the Deaf and Hard of Hearing, Division of

In assisting deaf seniors and those with hearing impairments to obtain necessary aids, the division will:

- seek collaborative opportunities with organizations willing to provide hearing aid repairs at no charge.
- seek funding to continue the hearing aid grant program for seniors and assist seniors having financial limitations to obtain hearing aids.
- offer education on improved assistive technology to staff and participants of senior centers and staff and residents of retirement and long-term care facilities.

- provide outreach and community education events statewide during Deaf Awareness Week and Better Hearing and Speech Month, including such services as free hearing screenings and information and referral.
- expand outreach and training for the Telecommunication Equipment Distribution Program (TEDP), which is administered by the statewide Telecommunications Access of North Carolina (TANC) program.

In promoting the quality of life of deaf seniors and those with hearing impairments, the Division will:

- expand hearing loss support groups and establish a Deaf Seniors group.
- pilot at least one "Confident Living" class, designed to teach participants about vision and hearing loss, available accommodations, and coping skills.
- develop resources for deaf caregivers.
- provide application assistance at all Regional Resource Centers for seniors to apply for North Carolina Senior Care services.
- promote mental and physical activities for deaf seniors.

Social Services, Division of

In striving to protect vulnerable older adults, the Division will:

- develop standards for Adult Protective Services (APS), develop an expanded training program for APS staff, and create a quality assurance system for the APS program by building upon an extensive needs assessment conducted in 2002 and the work of a task force and four regional groups.
- promote a consistent and collaborative community approach to the delivery of guardianship services by building upon recently developed guidelines and assisting social work staff in county departments of social services to incorporate these guidelines into their everyday practice.
- pending authorization by the General Assembly, expand the Special Assistance Demonstration Project to additional counties so that older and disabled adults in need of adult care home level of care will have the option of living at home instead of moving to an adult care home.

Vocational Rehabilitation Services, Division of

In promoting employment for eligible older persons with disabilities, the Division will:

- provide training and work-related services through its Vocational Rehabilitation (VR) Services program.
- explore and develop outreach efforts to eligible older persons with disabilities to achieve an employment outcome through the Division's VR program.
- explore and identify outreach strategies to expand service delivery to meet the evolving needs of older working individuals with disabilities.

In promoting participation in community, quality of life, and independence of older adults with disabilities and their families, the Division will:

- collaborate with statewide and community partners in developing service plans through the Independent Living (IL) Services program to assist eligible older adults with disabilities to obtain and maintain their independence in managing their lives in homes and communities—including the nursing facilities transition partnership effort with the NCDMA and community partners.
- provide assistance to eligible older adults with disabilities in securing housing and obtaining assistive devices to facilitate an accessible and affordable living environment through the IL program.

- provide hands-on demonstration of assistive technology, short-term loan to try out devices, and technical assistance in selecting devices to older adults and their families through the Assistive Technology Program (ATP).
- provide advocacy services for individuals and their families on their rights to assistive technology services—including funding and community resource information and referral to other programs.
- assist eligible older adults in obtaining supportive care for independence and community living through various community programs, including consumer-directed care through IL-reimbursed, consumer-managed personal assistance, as appropriate.

Other State Agencies

Seniors' Health Insurance Information Program (SHIIP) of the Department of Insurance

In continuing its activities that are integral components of an insurance counseling and assistance program, SHIIP will:

- conduct outreach activities to underserved populations as well as the general public by offering a toll-free telephone counseling service.
- inform the public about long-term care funding and payment options, with particular targeting of employers and baby boomers.
- assist Medicare beneficiaries affected by Medicare+Choice terminations.
- support the objectives of the Medicare Lookout Program by helping Medicare beneficiaries who have identified possible health claim discrepancies.
- promote computer use and Internet access among seniors as a medium for education and information.
- make health insurance information easily accessible statewide by partnering with public libraries and utilizing their facilities as sites for counseling, training, and resource materials.

In expanding the scope of its service, SHIIP will:

- focus on strategies to reach Hispanic, African-American, and disabled populations.
- initiate special efforts to respond to persons who have specific needs or concerns, including those who have high prescription drug costs or disabilities.
- explore effective ways to educate the disabled population on recent insurance laws that expand Medicare supplemental insurance plans.
- educate family caregivers on issues involving health insurance.

NC Housing Finance Agency

In promoting affordable, safe, and decent housing for seniors with low to moderate incomes, the Agency will:

- develop more affordable units with supportive services for older adults with low to moderate income.
- assist older adults and their families through consumer protection and housing rights programs.

Appendix C

Area Agencies on Aging

Region (Counties Served)
Director
Address
Phone
Web address

A (Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain)

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Acknowledgments

The Division of Aging appreciates the many individuals and agencies who contributed to the development of the *2003–2007 State Aging Services Plan*. The Healthy Aging chapter was written with the assistance of an ad hoc advisory group, as was the Economic Security chapter. The DHHS Long-Term Care Cabinet was instrumental in preparing the chapter on Long-Term Care and Aging. The Division also presented an overview of the *Plan* to the Governor's Advisory Council on Aging and the Area Agencies on Aging, seeking their input.

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*Special thanks to the UNC Institute on Aging and to AARP for supporting meetings of these two advisory groups.

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